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ABSTRACT

History shows that humankind has always had an appetite for psychoactive substances. Since young people are especially vulnerable to drug abuse, the etiology, epidemiology, and prevention literature on substance use by school-aged children are examined in this booklet. It gives information on, and examples of, preventive approaches and programs in schools and communities in addition to providing guidelines for preventive work. Because of the diversity of substance use and prevention goals around the world, the information and guidelines presented here are stated in general terms. The book opens with an overview of drinking, providing examples of drinking behavior, drinking styles, and risks associated with alcohol use. Drug use among young people is discussed next, including reasons why young people use drugs. Tobacco use by children is then examined, along with determinants of tobacco use and the harm tobacco can cause. Prevention is the focus of the text and examples of health promotion within schools are provided. Tips on working with community members, working with other agencies, and working with parents are offered. Emphasis is also placed on education in the schools, on policies for developing prevention in schools, and on youth organizations, such as community sports clubs and prevention clubs. (RJM)

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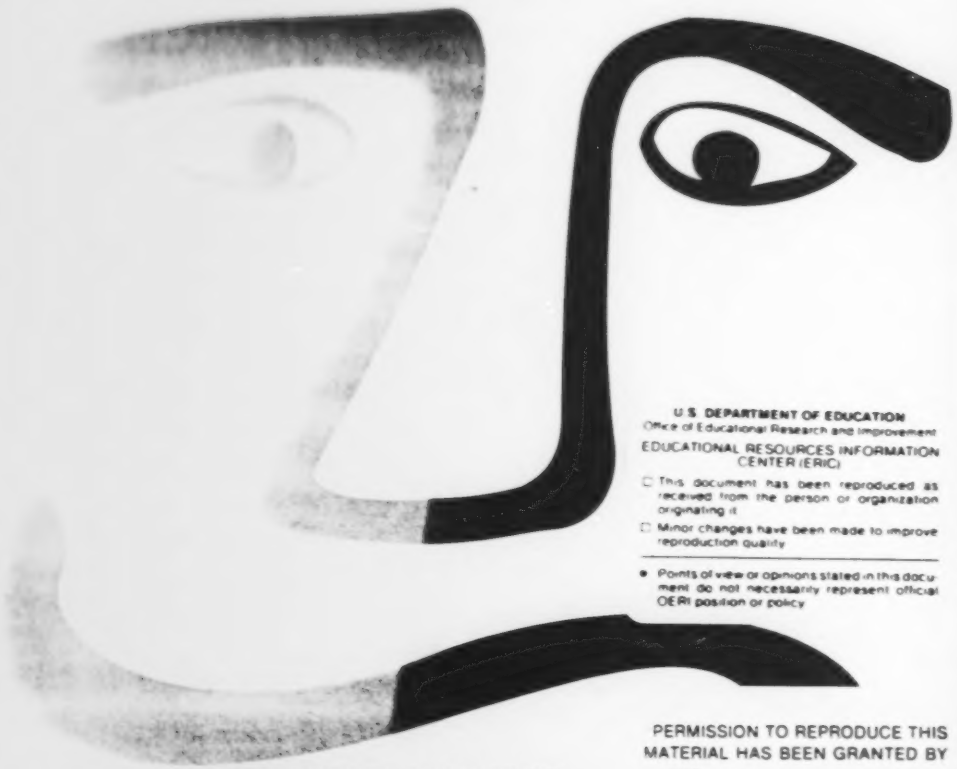

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World Health Organization
Regional Office for Europe
Copenhagen

Young people and alcohol, drugs and tobacco

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Introduction

This booklet:

- examines the ettological, epidemiological and prevention literature on substance use by school-age young people;
- gives information on and examples of preventive approaches and programmes in schools and communities; and
- provides guidelines for people doing preventive work.

The breadth of this field of inquiry limits the amount of detail that could be devoted to any one subject. Issues less directly linked to prevention, such as the influence of advertising, price and availability, are largely unaddressed. Nevertheless, these factors influence alcohol and tobacco experimentation and use, and people involved in preventive work with young people should take them into consideration. These issues are discussed elsewhere in this series.

SUBSTANCE USE AND RELATED PROBLEMS IN EUROPE

History shows that humankind has always had an appetite for psychoactive substances. Alcohol, opiates, cannabis, tobacco or other mood-altering substances have been used at some time in most countries, even in those that now proscribe their use. Depending on the country and time, the use of psychoactive substances has various social and cultural meanings. This seems especially true of alcohol. For example, in grain-producing regions, one usually finds a partiality for beers and spirits, while wines are favoured in vine-growing areas. Tobacco use is more global: nicotine addiction and seductive tobacco advertising have penetrated even the most remote areas of the world.

The use of other substances is much more closely aligned with cultural preferences and legal status. In European countries, the use of tobacco and alcohol certainly carries far fewer legal restrictions than that of other psychoactive substances. As is well known, even the use of legal substances can lead to personal and social harm.

The costs to the individual and society of the inappropriate use of alcohol are numerous and well documented. The morbidity and premature mortality associated with alcohol-related diseases, accidents and violence not only affect individuals but impose on society an undue burden on the health, social welfare and criminal justice systems. The health problems associated with alcohol use include various types of cancer (especially of the digestive organs), liver cirrhosis, cerebrovascular disease, and temporary and chronic harm to mental health. Alcohol is implicated in many road traffic accidents involving vehicle occupants, pedestrians and cyclists, and in public order offences. In addition, alcohol-related violence, separation and economic instability can harm family life. In the workplace, problem drinking lowers productivity through absenteeism, decreased work performance and accidents. The total cost to society of alcohol-related problems cannot be calculated, but the economic price has been tentatively estimated at 5–6% of the gross national or domestic product of any western country.

In general, tobacco-related harm is seen as more personal, although the morbidity and mortality associated with environmental tobacco smoke receive increasing recognition. Smoking has been established as a cause of lung cancer and some respiratory diseases, and a factor in the development of some other cancers, heart disease and stroke. Tobacco is the single most damaging psychoactive substance. Its use accounts for six times as many deaths as all other avoidable causes combined. Recent research has noted that half of all smokers will die from smoking-related diseases. Maternal smoking is known to impair the development of the fetus, while parental smoking can adversely affect the health and development of children. Although the dangers are well established, the worldwide use of tobacco products continues to rise.

Harm from the use of psychoactive drugs, both prescribed and illicit, varies widely depending on the substance. In general, however,

the use of drugs is seen as inherently harmful and something to avoid. Because of their relative inexperience, physical vulnerability and possible predilection for taking risks, young people are the main targets of messages against drug use. Some messages, such as "Just say no!", are unambiguous and have both political and popular appeal. Such messages however, ignore the various internal and external factors that influence one's decision to use or to avoid a given substance. Encouragingly, policy-makers, researchers, health and education professionals and others are developing and implementing strategies and programmes to prevent substance use by young people that address these factors.

This publication describes some of the strategies and programmes that have been implemented in the WHO European Region. To place such initiatives in context, the etiological and epidemiological aspects of substance use by young people are first discussed. Because of the diversity of not only substance use and prevention goals but also political agendas and structures, and methods of data collection, the information and guidelines presented are stated in general terms. It is nevertheless hoped that this publication provides a useful overview of prevention priorities and actions in a selection of European countries. It gives special emphasis to programmes in schools and communities and, where appropriate, cites research and experience from outside the Region.

1

Drinking and Young People

Although cultures vary widely across the Region, many young people grow up in an environment in which the consumption of alcohol is a normal part of life. Whether the cultural norm is to have a litre bottle of wine with the midday meal, or a round of drinks in the pub after work, most drinking is seen as a legitimate and enjoyable pursuit. In many cultures, alcohol is an essential ingredient of special occasions and rites of passage, as well as an aid to personal and social relaxation. In addition, the possible protective effects of moderate alcohol consumption, particularly against heart disease, have been widely discussed. The notion that alcohol has therapeutic properties is not new: hot red wine has long been a breakfast drink for children in some rural areas of Greece.

Many people drink alcohol without obvious harm. Some, however, consume alcohol in a way that causes harm to them and others. At its most severe, heavy or inappropriate drinking may have fatal consequences, mainly from liver disease but also from dependent and nondependent use and toxic effects. In the European Region, deaths attributed to liver disease vary widely in rate but in general are higher in southern countries, although these deaths have been declining in most age groups since the late 1960s. Norway, the Netherlands and the United Kingdom have experienced an increase in mortality rates, but these are still lower than those in southern, eastern and central Europe. In 1992, the age-standardized liver cirrhosis mortality rates ranged from a low of 2.9 per 100 000 in Ireland to a high of 54.8 in

Hungary. National beverage preference was not linked to incidence: both beer- and wine-drinking countries figured in the higher rates.

Most harm incurred by young people is related to the associated effects of intoxication, namely hangovers, accidents, and social and legal problems. These immediate problems and the need to prevent future harm from the inappropriate use of alcohol make it important to monitor the use of alcohol by young people and to implement appropriate educational and public policy strategies.

DRINKING BEHAVIOUR

The consumption of alcohol by young people is not uncommon. Despite restrictions on drinking by those under a certain age, a significant proportion of school-age youth consumes alcohol at least occasionally. Accurate figures on use, however, are difficult to determine. Surveys provide most of what we know about whether, how much and what young people drink. Because of differences in the methodologies and criteria of surveys, as well as in the social acceptability of drinking, comparisons within and between countries are not always helpful. For example, interpretations of drinker categories (such as light or occasional) differ, as do definitions of a young person. The reliability of self-reported survey data is also a potential problem. Some people certainly underreport their drinking habits, while others exaggerate. Even so, surveys and other reports from various countries of the Region reveal interesting information when viewed individually. In addition, a few recent cross-national studies reveal general trends in the use of alcohol by young people. Information from such studies, as well as reports from informants contacted during the compilation of this publication, are used to discuss drinking by young people in the European Region.

Prevalence

Most surveys reveal that most people have at least tasted an alcoholic drink by the age of 18. For example, a WHO survey on the health behaviour of school-age children (HBSC) examined the prevalence of experimentation in three age groups (children aged 11, 13 and 15 years) in 1989–1990. The HBSC survey revealed that only a very small minority had never tasted alcohol by the age of 15 (*1*). Across

the age groups, more students in Wales and Scotland reported having tasted alcohol than in all other countries, with Norwegian students reporting the least experimentation. By the age of 15, however, the variation between children in different countries was not very great. Of the 11 countries for which comparable data were available (Austria, Belgium, Canada, Finland, Hungary, Norway, Poland, Spain, Sweden, and Scotland and Wales (United Kingdom)), only Norway showed an experimentation prevalence of less than 90%. As to gender differences, males reported more experimentation than females at the age of 11 but 15-year-olds showed few gender differences. Many other studies confirm this pattern. There is a distinct gender difference in the amount of alcohol consumed: worldwide, older males consistently drink more than older females.

Further, the HBSC survey examined weekly use of alcohol by age and gender. The proportions of weekly drinkers at age 11 were relatively low for all respondents, but were substantially higher in those aged 15. The percentage of 15-year-old males who drank at least weekly ranged from 10% in Poland to 47% in Wales, with most countries falling between 32% (Scotland) and 42% (Spain). Females were the least likely to drink at least weekly, but as with males, prevalence rose with age. At the age of 15, respondents from Wales and Spain were nearly ten times more likely to report weekly drinking than their Polish counterparts (35%, 29% and 3%, respectively).

A 1990 European Community (EC) cross-country study of tobacco and alcohol use by children aged 11–15 years overlapped with the HBSC survey; it covered Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and Great Britain (United Kingdom) (*2*). This survey noted that young people from Greece and Italy were the most likely to drink on a weekly basis, while those from Ireland were the least likely. Only 2% of Irish males and 1% of Irish females aged 13–15 years reported this drinking pattern. An Irish study conducted in 1990, however, found that 23% of respondents (average age 15) drank once or twice a week. The EC study confirmed that weekly drinking greatly increases with age, with females tending to drink less often than males. Further, neither of the cross-national surveys found daily drinking to be prevalent.

Results from the HBSC survey indicate that alcohol intoxication is not uncommon. By the age of 15, 24–70% of females and 42–74% of males reported having been drunk at least once. Young people in Poland and Wales, respectively, were least likely and most likely to report ever having been intoxicated. Again, prevalence increased with age. Countries outside the HBSC survey have reported similar findings. For example, nearly half of recently surveyed Slovenian youth (14–15 years old) had been intoxicated. For some young people, intoxication is a result of unpremeditated overindulgence and inexperience. For others, it is a goal in itself and may be symptomatic of problem drinking. Many young people do not consider occasional drunkenness to be harmful.

Beverage Preferences

In contrast to adults, young people show quite uniform beverage preferences. Overall, reports indicate that young people demonstrate a distinct preference for beer, followed by wine and spirit-based cocktails. The Mediterranean model of wine drinking is gradually losing its predominance among southern European youth. Sweet liqueurs and so-called national drinks, such as *raki* in Turkey and cider in the United Kingdom, also figure in young people's preferences.

A worrying trend in the United Kingdom is the popularity with children and young adolescents of strong, sweet, flavoured cider drinks. Manufacturers seem deliberately to target the market of young drinkers with inexpensive, trendily packaged cocktail-type drinks. For example, they produce strong ciders with kiwifruit-banana and strawberry-vanilla flavours in containers shaped like light-bulbs, sticks of dynamite or test tubes. Young males and females find these drinks a quick, cheap and palatable way of becoming intoxicated.

As to gender differences, males in the HBSC survey tended to drink more beer than any other beverage, except in Hungary; almost all drank wine at least occasionally. Females, on the other hand, preferred wine, although more Swedish females drank beer and more Austrian females drank spirits. Other surveys indicate that distinctions between socialization and transgression in drinking are such that males were more inclined to the latter; females' drinking had more to do with seeking approval and wanting to belong. Males, regardless of age, consumed much greater quantities of alcohol more frequently,

and were more likely to drink to intoxication. The choice of beverage also mirrored this dichotomy: males more often drink spirits, which were seen as a means of transgression. The worst problems of excessive and inappropriate alcohol use were typically associated with spirits, although beer drinking was more likely to have this association in Germany and the United Kingdom (*3*).

Settings for Drinking

Settings for drinking different beverages are fairly uniform. Young people are more likely to drink wine and aperitifs with a meal at home, and to consume other alcoholic beverages with their peers at parties, sporting events, public houses and other unsupervised venues. Alcohol consumption by young people, regardless of beverage type, is more likely to take place away from the home and other places that exert social control. Because drinking away from parental control is either proscribed or heavily regulated in many countries, young people usually favour locations with the least perceived control. Although legislation may have the potential to limit underage consumption in the public houses and bars of some countries, it seldom does so. These venues are very popular with young people in most areas of the Region.

Other places where adolescents socialize and drink alcohol include discos, nightclubs, dance halls, parties and, in Greece, fast food restaurants and cafeterias. Students in urban areas of France congregate in cafés, as well as bars. Countries differ in the legal availability of alcohol to young people, and in restrictions on age, type of beverage, whether food is concurrently consumed and settings or locations. Enforcing legislation that restricts underage drinking can affect, if not covert experimentation, the levels of overall consumption and related problems.

Although young people sometimes drink on weekdays, often with the family, they do most of their drinking on weekends, away from the home. This is the case even in countries such as Hungary and Spain, where the proportion of drinking in the company of family members remains high. Public drinking is strongly associated with age. The older the adolescent, the more likely he or she is to drink away from home. The age at which adolescents drink in public appears to have fallen in the past two decades. Aside from the gradual

lifting of social taboos on public drinking by young people, especially females, young people today tend to be virtually indistinguishable from adults. In addition, geography figures highly in the choice of drinking location. Young people in urban areas usually have more choices than their rural counterparts of places where they can drink with some anonymity.

Trends in Consumption

Trends in whether and how much young people drink are much less clear. The collection of information on drinking habits in this age group is a fairly recent activity in most countries. For this reason, only a limited basis exists for monitoring trends in alcohol use by the young. Even so, a number of studies indicate that the proportion of abstainers is rising in many countries, such as Germany and Sweden. Data on levels of consumption per episode have proved very difficult to compare, but some countries have noted an increase, such as the Netherlands and Spain. Overall, drinking appears to be less frequent and more episodic in young people than in adults, although adults are more likely to consider themselves to be nondrinkers. Sweden, however, has shown a distinct decline in consumption levels in young people.

DEVELOPMENT OF DRINKING STYLES

Most young people will have had a sip of an alcoholic drink, or even a small glassful, at a very early age. This experimentation takes place primarily under the guidance of an adult family member. Deliberate drinking usually begins at a somewhat later age. This age varies between countries and has been decreasing in most western European countries, except the Netherlands. By the age of 15, most youths who have made the decision to drink are doing so, invariably in the company of peers. Habits and styles of drinking among young people change rapidly and are very much influenced by peer use, advertising, availability and price. The influence of peers is particularly strong during early adolescence, when young people begin to assert their independence from their parents and form friendship groups. During this transition from childhood to adulthood, adolescents experiment with a variety of roles and behaviours that they see as part of adult life. Being an alcohol drinker is one of these roles. It is also not

unusual for adolescents to begin to engage in a variety of risk-taking behaviour to test their limits and to combat parental restrictions. Breaking legal and social rules is not uncommon. Because adults in most western societies accept alcohol consumption, it is not surprising that most people start drinking in adolescence.

The drinking styles of young people in the Region often differ considerably, in quality and quantity, from those of their parents. Even so, the strongest external influence on whether and how much young people drink appears to be their parents' use of alcohol and styles of drinking. Young people begin to learn about alcohol from an early age by watching parents' and others' behaviour.

In some countries, extremes of parental alcohol use appear to have a distinctly negative influence on the style in which their offspring drink. The children of heavy drinkers and of abstainers are more likely to drink heavily or with problems. Children born into Muslim families or in areas of low availability and use of alcohol, such as parts of the Scottish Highlands and Islands, however, are exceptions. Even in homes where alcohol is not used, children are undoubtedly aware, to some extent, of alcohol and its effects. Research into children's awareness of and attitudes about alcohol indicates that alcohol education should begin earlier than is the norm in most countries (usually in secondary school) and that parents should take part (*4*). Children tend to underestimate the risks involved in alcohol use. Appropriate, age-targeted education may help to equip children better for the time when they will need to make decisions about their use of alcohol. The content and teaching methodologies should take account of norms about alcohol and children's experiences of the attitudes and beliefs of their families.

WHY SOME YOUNG PEOPLE DRINK

Young people drink for many reasons, which vary with their personal and social circumstances. Some of the most commonly cited reasons include wanting to belong or not to be different, boredom, pleasant taste, and a belief that alcohol makes one feel better or more sociable. Many young people, however, are unable to identify a specific reason.

This suggests that there are many influences, most probably relating to normative social behaviour.

Most young people drink among groups of friends, when alcohol is usually a part of socializing. Music, dancing, sport, celebration or just relaxed conversation is often the focus of gatherings, with alcohol an essential but secondary ingredient. Members of the group invariably drink for different reasons and effects, although the belief that everyone drinks is probably one of the primary reasons. Intoxication among these drinkers is largely unpremeditated, but not infrequent.

Some young people, on the other hand, may drink heavily and frequently for the purpose of intoxication. Drug taking and other risky behaviour is more associated with this style of drinking, and problems and negative coping strategies contribute to its development and continuation. While a distinction is made between social and heavy drinking, the former is not without problems. Many social drinkers consume a lot of alcohol at one time and become intoxicated quite regularly, increasing the potential for incurring harm.

The underlying factors in young people's drinking choices are numerous and often interrelated. They change in importance as young people approach adulthood. Views of these factors, however, vary across the Region, and the various perspectives have much to do with the traditions and practices of each country. While there is no universal risk profile for young alcohol or drug users, researchers cite many factors, depending on their theoretical perspective. Some of the social, demographic, psychological and social environmental factors include:

1. knowledge of and previous experience with alcohol
2. other lifestyle-related health behaviour
3. personal or psychological predisposition (such as coping strategies or sensation seeking)
4. motivation to drink or abstain
5. hedonism
6. self-medication
7. gender

8. religion
9. level of curiosity, alienation and boredom
10. peer pressure or peer use
11. parental use and attitudes
12. relationship with parents
13. sibling use
14. pressure from or images in the mass media
15. family socioeconomic status
16. frequenting of discos and other public entertainment venues
17. pocket money or allowance
18. price and availability of alcohol
19. perception of peer norms and societal and cultural norms
20. other historical, cultural, political and economic factors relevant to the country or area concerned.

HARM FROM INAPPROPRIATE USE OF ALCOHOL BY YOUNG PEOPLE

Some young people suffer from the consequences of their drinking. Although the proportion of adolescents who consider themselves to be drinkers has probably declined, evidence on consumption levels points to an overall increase. Even in areas where consumption has not risen, some drink inappropriately and experience adverse effects. Most young people in the Region drink at least occasionally. The vast majority experience intoxication and other minor short-term consequences. A minority, however, drink heavily, increasing the risk of more serious and long-lasting harm. The etiology of such alcohol use by young people remains uncertain (5). Even those who do not drink heavily can come to harm, or harm others, through the inappropriate use of alcohol. Some evidence suggests that heavier drinkers are more likely than other adolescents to use illicit drugs and engage in other risky forms of behaviour (such as unprotected sex and drink–driving)

even if they do not remain heavy drinkers (6). In general, drinkers are more likely to use tobacco products.

Intoxication and heavy, frequent drinking are associated with a sizeable proportion of accidents and public order offences. Aside from the physical symptoms of intoxication, the consequences are often hard to quantify. It is not always clear, even if a person has been drinking heavily, to what extent alcohol may be responsible for a given problem. People react differently to the same quantity of alcohol, depending on such factors as mood, the physical and social environment, the time span of the drinking episode, and whether they have eaten beforehand. Even so, heavy drinking and intoxication are associated with much criminal and antisocial behaviour by youth. To summarize, the types of harm associated with the inappropriate use of alcohol by young people include:

1. hangover symptoms (such as headache, sickness, diarrhoea, temporary short-term memory loss and temporarily dulled cognition);
2. decreased educational achievement in the medium or long term;
3. arguments or fights;
4. other violent behaviour, some criminal behaviour or public disorder problems;
5. impulsive behaviour;
6. inappropriate behaviour;
7. accidents resulting in injury or death;
8. mood change;
9. accidental poisoning;
10. increased likelihood of partaking in other potentially harmful behaviour such as unprotected sex or drug experimentation; and
11. related family and/or social problems.

Some governments have taken steps to reduce the risk of problems by enacting legislation that restricts alcohol consumption in areas that are associated with offences related to drunkenness. Scotland, for example, has restrictions on the carriage, sale and

consumption of alcohol at sporting events, particularly soccer matches, and on trains and buses carrying spectators to such events. In addition, public drunkenness in Scotland has been decriminalized to some extent; some people who might formerly have been convicted of public order offences are instead referred for alcohol counselling or treatment.

CONCLUSIONS

At all ages, most young people who drink do so in modest amounts. A significant minority, however, drink heavily, and this proportion seems to rise with age. The vast majority of alcohol-related problems among young people relate not to alcohol dependence or even chronic heavy drinking, but to the unpleasant side effects of acute intoxication. One can say that young people are only mirroring the popularity and acceptability of alcohol in society at large. Nevertheless, alcohol can cause personal and social harm if used inappropriately. Alcohol's enduring popularity ensures that children and young people will always find it attractive. It is for this reason that priority should be given to policy and education that foster the formation of appropriate attitudes.

2

Drug Use and Young People

Drugs of one kind or another have been a feature of most cultures throughout history. People have long used herbs, as well as fermented beverages, for various purposes: to relieve pain, cure illness, induce altered states of consciousness, escape from painful experiences and situations, and enjoy themselves. Religious and cultural customs play a major role in the acceptability and use of drugs. Some drugs are an integral part of certain religious rituals; some cultures and religions forbid all drug use.

Most people in the European Region engage in some form of drug taking, which is mainly legal and sometimes highly enjoyable. People in most European countries use alcohol, caffeine and pharmaceuticals to some extent and, for the most part, incur little or no harm. All drugs by their very nature, however, have the potential to cause harm if used heavily, chronically or inappropriately. For this reason, most drugs have controls on their manufacture, distribution and use. These range from the so-called child-proof packaging of many over-the-counter analgesics, to the availability of tranquillizers on prescription only to the complete prohibition of such drugs as 3,4 methylenedioxymethamphetamine (MDMA or "Ecstasy"). Many countries forbid the sale of alcohol and tobacco to children.

Despite measures in most countries of the Region to control the supply of illicit and prescribed drugs, some people seek to obtain money by selling them illegally. The market for illicit and illicitly obtained drugs is part of a complex web of international changes in

the agricultural, economic and political structures of many developing countries, the spread of organized crime, and the increase in international travel and trade. The availability of different substances varies, but many potentially harmful ones are readily found in all countries, particularly in urban areas.

Even though the use of illicit drugs appears to cause little harm in comparison with other, more widespread health problems such as heart disease and cancer, it can have a devastating effect not only on users but also on their families and society. This effect includes, apart from short- and long-term health consequences, harm related to behaviour, family and social life, employment and schooling. The manifold attractions of illicit drugs, coupled not only with their relatively widespread availability but also with the reasons people use them, ensure that the problem of drug use will not be easily solved.

DRUG USE BY THE GENERAL POPULATION

In comparison with legal substances, such as alcohol and tobacco, illicit drugs are not widely used. Even so, the proportion of people who have ever used them has increased over the past decade. Data from general population surveys indicate that, in the 1980s, most western European countries had prevalence figures of 5–10% (*7*). Surveys conducted since 1989 have noted a prevalence of lifetime use for cannabis or illicit drug use of 6% (in people aged 15–74 years in Finland in 1992) and 22% (in people over 16 in Denmark in 1989/1990). Most countries have experienced a rather marked increase in lifetime prevalence since the early 1980s. In 1992, for example, 17% of those surveyed in the United Kingdom had ever used drugs, compared with 5% in 1981 (although the 1992 survey covered a larger age group). Spain is a notable exception, having registered a steady decrease in prevalence from 20% in 1980 to 12% in 1989. This may be due, in part, to a change in research methodology.

An examination of surveys that distinguish between age groups, reveals that much of the overall increase in prevalence may be due to use among young people. Prevalence did not rise in the older groups surveyed. In Switzerland, for example, a 1992 survey noted lifetime use prevalence figures of 21% for people aged 17–30 years and 14%

for those aged 31–45. Drug use among the Swiss appears to be increasing among the younger cohorts, and decreasing among older cohorts. This may also be true of other countries of the Region.

DRUG USE BY YOUNG PEOPLE

Surveys of drug use among young people have yielded very little information for international comparison. The 1995 Pompidou Group survey of adolescent alcohol, tobacco and drug use in 26 countries, however, will do much to rectify this deficiency. Surveys of self-reported drug use among young people are fairly recent, although Finland, the Federal Republic of Germany, Sweden, the United Kingdom and some other countries have conducted them since the early 1970s. Such surveys often cover wide age bands, such as people aged 15–29, and details of use patterns by age can become blurred. Because the prevalence of drug use by European school-age youth is quite low, it is difficult to attach meaningful interpretations to any changes over time. As mentioned, apparent changes in prevalence can be attributed to change in research methodology. There are other problems, too. Gathering reliable information on the use of any substance is notoriously difficult, especially when it comes to children and adolescents. Surveys of young people are beset by problems related to under- and overreporting. Underreporting is acknowledged to be a significant problem in interpreting surveys on alcohol use, which is legal; interpreting the results of drug use surveys very probably involves even greater limitations. The proscription of and restrictions on the use of many substances by children, however, means that anonymous surveys are one of the few ways to measure the use of a given substance by young people.

Despite their flaws, surveys indicate the approximate scale and patterns of use and availability of drugs. Other, indirect indicators of levels of drug use include treatment, mortality and crime statistics. These, however, may say more about the functioning and policy of the health and justice systems than about drug prevalence levels. Most drug users, whatever their age, do not come to the attention of official agencies.

Although no comparable cross-national data are yet available on the prevalence of drug use among school-age youth, the first European summary on drug abuse notes a trend that relates indirectly to this age group (*8*). Over the period 1985 to 1990, the average age of drug users (namely, those in treatment) increased in nearly all reporting countries. Other reports, however, note that the age of those experimenting with drugs is becoming lower. This may imply that, although drug use is beginning earlier in life, either young people are limiting themselves to experimental or occasional use, or their pattern of use (drug type and method of use) does not yet affect the type of treatment services available. In the United Kingdom, at least, young people certainly appear to be moving away from opioids towards hallucinogens and stimulants. The service profile is shifting to meet the new needs of an emerging group of young chronic non-opioid users, while still helping the older opioid users. Regardless of users' age or country, cannabis products are by far the most frequently used drugs. Most cannabis users never come into contact with treatment agencies or the police.

Recent information from individual countries on the use of drugs by young people indicates a mixed and inconclusive picture. For example, while surveys in Norway show a small decrease in the proportion of people aged 15–20 who have ever used drugs (from 3.1% in 1986 to 2.66% in 1993), there has been a small increase in reported cannabis use. The Netherlands notes that, among people aged 12–18, the prevalence of lifetime use of cannabis use rose from 5% to 13% between 1984 and 1992. Over the past two decades, Sweden has seen a steady decrease in the number of adolescents who have ever used illicit drugs.

Some countries have noted stability in the proportions of those ever using drugs. Between 1989 and 1992, the figure for people aged 12–18 years in Portugal remained at 5%. In the Federal Republic of Germany, the figure for people aged 12–25 remained at 17% over the period 1986–1989. In the former German Democratic Republic, however, the lifetime prevalence for people aged 12–29 years rose from 1.1% in 1990 to 2.7% in 1992. A 1993/1994 survey showed that the figure for people aged 12–17 in Germany was 7%.

Although reliable data on current use are more difficult to obtain than those on lifetime use, the available evidence suggests that the proportion of current users among young people has increased over the past decade, although it is invariably smaller than that of young people who have ever used drugs. Some studies indicate that the former in general comprises one sixth to one third of the latter. The proportion of regular drug users (at least once a month) appears to become higher as young people enter their late teens. Most illicit drug use begins sooner than in previous decades – usually between the ages of 13 and 17 – although countries such as Norway have noted an increase in the age of first use. Some young people, however, start their drug use career much earlier. Numerous studies have shown that few people try drugs for the first time after the age of 20. Regardless of age, most people use illicit drugs neither heavily nor habitually.

Overall, adolescents appear to differ very little from adults in their drug preferences: 75–90% of drug users in the European Region use cannabis on its own, or with other drugs. Two key differences, however, appear in most countries. First, children and young adolescents in many countries (such as Finland, France, Norway, Portugal, Romania, Spain and the United Kingdom) have a penchant for volatile substances (inhalants) such as solvents and gases. This preference is mainly opportunistic. Volatile substances are readily found in most homes, and are cheaply available in shops. Second, the use of hallucinogens, especially stimulants, has rapidly increased among older adolescents and young adults in many European countries. In some countries, stimulants are not considered illicit drugs, but their non-prescribed, recreational use is growing in popularity. In countries such as Belgium and Greece, pharmaceuticals such as tranquillizers are preferred to illicit drugs. Drugs that are increasing in popularity include amphetamines, lysergic acid diethylamide (LSD) and MDMA. Cocaine and heroin use among school-age young people appears very low, although multiple drug use, previously the preserve of the older user, is increasing in some areas. Such popularity, at least initially, is associated with increased availability and lower price.

Most school-age young people do not use illicit drugs. Certain areas and subgroups, however, have a higher prevalence of drug users, as well as increased likelihood of harmful behaviour, such as drug injection and equipment sharing.

WHY YOUNG PEOPLE USE DRUGS

Many factors help to determine whether a person will try drugs and continue to use them. The complex nature of drug use has made it difficult to determine whether experimentation with and use of one drug serves as a gateway to the use of other, harder drugs. Although some people experiment with a drug such as cannabis, or hashish, far fewer continue using it and fewer still go on to use other illegal drugs. What is known about the establishment of a drug career is that the use of tobacco and the heavy use of alcohol are associated with the use of illicit drugs (*6*). In addition, drug experimentation and use usually begin in adolescence. People who go on to use drugs frequently are more likely to use a variety of drugs.

Table 1 shows factors associated with drug use. These are correlates only: causal links are as yet unidentified. A significant proportion of these factors can also be associated with people who do not use drugs, while very few may affect some drug users. Three of the most frequently cited in association with experimentation include curiosity, availability and peer group use. Availability and price, as well as peer group use, have been linked to continued drug use. Harmful or heavy drug use appears to be related more to social and psychological disadvantage, such as unemployment, family disruption and other stressful life events. Survey-elicited reasons why people aged 15–25 used drugs include (*9*):

- behaving like one's friends
- forgetting problems
- family problems
- relational problems
- loneliness
- scholastic or professional failure
- gaining self-confidence
- increasing performance
- making friends.

Table 1. Factors associated with drug use

Individual factors	Environmental factors
Personality	Socioeconomic status
Stress	Family background
Intelligence	Religion
Predisposition to take risks	Truancy
Self-destructiveness	Job opportunities
Attitudes towards use	Legal arrangements
Empowerment, control over life	Parental absence
Gender	Parental and sibling drug use
Need for power	Poverty
Psychological health	Peer pressure/peer use
Hedonism	Educational opportunities
Sensation seeking	Drug availability
Use of other substances	Anomie
Anxiety	Historical factors
Age	Parental concern (lack of)
Life events	Delinquency
Curiosity	Tradition
Intentions to use	Educational disturbances
Scepticism about prevention efforts	Drug price
Biological/genetic predisposition	Alienation
	Parental permissiveness
	Over- and underdomination by parents

Source: adapted from Plant & Plant (*6*).

HARM FROM DRUG USE

For many young, inexperienced users, taking illicit and unprescribed drugs is a largely pleasurable experience. Whether they want to feel more sociable, energetic or relaxed, or to numb themselves to unpleasant feelings and experiences, young people find drug use an increasingly attractive and available option. While some young people emerge from drug use suffering little more than a lighter purse, many others encounter more significant consequences.

The immediate physiological effects of drug intoxication are numerous, depending on the drug. Using cannabis can lead to

temporary short-term memory loss and lethargy; using amphetamines and LSD, palpitations and raised blood pressure; using LSD, hallucinations; using sedatives and minor tranquillizers, impaired motor co-ordination; and using solvents and heroin and other opiates, slowed breathing rate. Some of these immediate effects can increase the risk of accidents. In rare instances, death can occur from the first use of a drug or after consuming a normal dose of for example, heroin or MDMA.

Effects in the longer term are highly variable. The type of drug(s), the mode and frequency of use and, depending on the drug, genetic predisposition help to determine the impact of prolonged drug use. Long-term, frequent use of almost any illicit drug carries the risk of permanent damage to physical and mental health. There is also the very real risk of premature death, through accidents, accidental poisoning or overdose, and impurities. People who inject drugs, such as heroin, amphetamine sulfate or sedatives, run the risk of abscesses, septicaemia and gangrene and, if they share injecting equipment with others, the risk of contracting HIV and hepatitis.

Although most young people do not use drugs frequently or over a prolonged period, some do so. Harmful drug use can adversely affect family and social relationships, as well as lessen educational achievement. Some experts believe that truancy and drug involvement are linked. It has been suggested that reducing truancy may reduce some young people's risk of becoming involved with drugs (Plant, M.A., personal communication, 1994). Young users of drugs, regardless of the frequency of their drug taking or their choice of illicit drugs, are indulging in a criminal act. The desire for or dependence on drugs may in turn beget other criminal acts such as theft, drug dealing and prostitution, to finance drug purchases.

CONCLUSIONS

Drug use exacts a financial toll on society through costs associated with the criminal justice system, and the medical and social care of illicit drug users and their families. The pervasiveness of drug taking in many countries can negatively affect entire communities. Although primarily seen as an urban problem, illicit drug use is fast becoming

more prevalent in rural areas. In some areas, drug taking is considered normal behaviour. The failure adequately to respond to the factors that fuel this notion (and indeed, fact) will exact a high price from individual drug users and society as a whole. Drug use clearly flourishes in areas of deprivation, and where there is alienation and a lack of opportunities. Nevertheless, all young people are potential drug users.

The indications are that the prevalence of established drug use among young people is low in general, although experimentation levels show much variation by country, substance and social group. Bearing in mind the comparable data on trends, there appears to be little change in the proportions of European young people using drugs.

Appropriate drug education and a social and physical environment conducive to the adoption and maintenance of a healthy lifestyle increase the likelihood that today's youth will turn into healthy and productive adults.

3

Tobacco Use by Young People

Tobacco use is not a recent phenomenon. People in Europe have been smoking or chewing tobacco since the discovery of the Americas at the close of the fifteenth century. Tobacco quickly became a much sought-after substance, and has been an extremely valuable cash crop, at times displacing even gold in importance. During the mid-nineteenth century, advances in cigarette manufacture technology greatly increased tobacco's availability, while lowering its cost. Many people took up smoking, regarding it as fashionable. Manufacturers and even doctors extolled its health-giving properties to a receptive public. Tobacco was promoted not only as a stress reducer but also, incredibly, as a fumigant against germs. Like the use of alcohol, the use of tobacco eventually cut across all socioeconomic classes, a phenomenon that has only recently altered. During the early decades of the twentieth century, cigarette smoking increased sharply in most European countries. Owing possibly to differences in levels of awareness and tobacco control policies in countries, smoking prevalence has fallen at different rates and times since the 1960s. At present, the proportion of adult smokers in many countries has remained relatively stable or is slowly declining. No country has yet achieved the target of the WHO Action Plan on Tobacco: 80% of the population non-smokers by 1995. In general, the prevalence of smoking is slightly lower in women than in men, and men are more likely than women to be classed as heavy smokers (10 cigarettes or more a day) and ex-smokers.

Most industrialized countries show an inverse relationship between socioeconomic status and smoking. Studies have found highly significant differences between groups based on both number of years in full-time education and occupational classification. People with less education (those educated to age 16 only) and/or a manual occupation seem more likely to smoke and to smoke heavily than people with more education and/or a nonmanual job. Possible explanations for these differences include: fewer workplace restrictions on those in nonprofessional occupations and the phenomenon of social smoking, whereby those in professional occupations may restrict their smoking to social occasions (*10*).

HARM FROM TOBACCO USE

In the past few decades, tobacco has come to be known not for giving health but for taking life. It has been estimated that just over 1 million people in the European Region die of tobacco-related diseases each year. Just under half of these deaths occur in people under 65 years. Tobacco smoking is the greatest cause of premature, preventable death. It has been said (*11*) that: "tobacco is the only consumer product that can kill you if you use it exactly as intended by the manufacturer". The highly addictive constituent of tobacco, nicotine, heightens the risk of death: once started, smoking is often very difficult to give up. The addictiveness of nicotine has been likened to that of heroin and cocaine.

The scope of tobacco-related ill health is literally breathtaking: lung cancer, heart diseases, emphysema, chronic bronchitis, as well as stomach ulcers and stroke. People who smoke tobacco are at risk of seriously damaging their health, but those who chew tobacco are at risk of developing cardiovascular diseases and cancer of the oral cavity. Tobacco consumption, including environmental tobacco smoke, may account for up to 20% of deaths in some countries. An exact figure is difficult to determine, but the death rate in some countries is so great that it completely overshadows the number of deaths attributable to other external factors, such as alcohol, suicide and road traffic accidents. The British Royal College of Physicians put into context the sheer magnitude of the problem of tobacco consumption by noting that, of 1000 young men in England & Wales who smoke cigarettes,

on average about 1 will be murdered, 6 will be killed on the roads and 250 will die before their time from tobacco (*12*).

Warnings about the dangers of smoking have been published since the mid-1950s. In 1971, the British Royal College of Physicians took an unequivocal stance against tobacco (*13*):

> The suffering and shortening of life resulting from smoking cigarettes have become increasingly clear as the evidence accumulates. Cigarette smoking is now as important a cause of death as were the great epidemic diseases such as typhoid, cholera, and tuberculosis that affected previous generations in this country. Once the causes had been established they were gradually brought under control ... But despite all the publicity of the dangers of cigarette smoking people seem unwilling to accept the facts and many of those who do are unwilling or unable to act upon them.

In 1975, the WHO Expert Committee on Smoking and its Effects on Health made an equally damning report. The Committee concluded that (*14*):

> The evidence that cigarette smoking greatly increases the incidence of lung cancer is now irrefutable. It can therefore be forecast that, if cigarette smoking were to stop or if cigarettes free from the risk of cancer were to be produced, the world-wide epidemic of a disease that at present kills hundreds of thousands of smokers every year would be arrested ...

Tobacco use also harms nonsmokers. Since the 1970s, many studies have concluded that environmental tobacco smoke is associated with an increased risk of lung cancer in nonsmokers. This risk may be in the range of 10–30%. In response to this and related risks, many policies now restrict or prohibit smoking in specified areas of workplaces and public places. Unfortunately, although tobacco smoke adversely affects fetuses and young children, they are relatively unprotected by public policies. The evidence indicates that smoking is associated with numerous complications, including ectopic pregnancy, placental abnormalities, bleeding during pregnancy and low birth weight in babies. In addition, women smoking 20 or more cigarettes a day have an increased risk of spontaneous abortion. Sudden infant death syndrome is more likely in babies whose mothers

smoked during pregnancy and after giving birth. The harm continues after infancy. The children of parents who smoke have higher rates of pneumonia, bronchitis and other respiratory ailments, and chronic middle ear infections. Consequently, such children spend more days absent from school than their peers from nonsmoking households. Finally, smoking in pregnancy may affect the physical and mental development of children.

In adults, sickness due to cigarette smoking contributes to prolonged ill health, work absenteeism and decreased productivity. Although tobacco does not have the associations that alcohol and illicit drugs have with criminal and other antisocial behaviour, it clearly harms smokers and others. As predicted in 1975 by the WHO Expert Committee, countries in which tobacco use has decreased have seen a later but clear reduction in tobacco-related ill health. An interrelated combination of heightened public awareness of the harm related to tobacco, healthy public policy and changing social norms about the acceptability of smoking may be responsible for much of the decrease in tobacco use.

DETERMINANTS OF TOBACCO USE

The limited success of education to prevent tobacco use is shown in the fact that, despite awareness of the deadly risks, many young people continue to take up smoking. As with other substance-related behaviour, the acquisition of a smoking habit most often occurs during adolescence. Smoking is a relatively visible phenomenon; it is not unusual, at least in urban areas, to see groups of teenagers standing around puffing away on cigarettes. Nevertheless, the process of becoming a smoker is not yet fully understood. For a substantial minority of adolescents, knowledge and attitudes do not seem to have much bearing on smoking behaviour.

It is widely accepted that various psychological and social factors contribute to the onset of smoking. These include demographic factors (such as socioeconomic status), the social environment (such as family and peers), personality, psychosocial factors (such as self-image and anxiety levels) and biological factors (*15*). Such factors

intermingle and affect each other. For example, socioeconomic status influences the social environment.

Examinations of child and adolescent smoking behaviour have consistently demonstrated that smoking onset occurs in a series of consecutive stages. These stages evolve from preparation and anticipation, to initiation, experimentation and finally maintenance of regular smoking (*16*). The relative influence of the aforementioned factors seems to vary according to the smoking stage, although the relationships are far from clear-cut. Family and socioeconomic influences are thought to be of paramount importance at the preparation and anticipation stage, when young people are forming beliefs, values and attitudes. Attitudes towards smoking, however, do not always predict intended or actual smoking behaviour. Many young people, including smokers, have very negative attitudes to smoking.

Initiation and experimentation appear to be strongly influenced by peer use of cigarettes, with family use and attitudes waning in influence. Peer group pressure, however, may be overemphasized as a single influence. There is evidence that children and adolescents tend to form friendships with those most like themselves, much of this selection having to do with both personality and socioeconomic status. This implies that decisions about behaviour have more to do with mutuality of intention than undue pressure to conform. In comparison with persuasion, pressure and encouragement, less overt influences such as modelling may have a greater impact (*17*). In any case, more personal psychosocial factors largely drive continued experimentation. The pharmacological effects of tobacco – nicotine dependence – heavily influence the progression to regular smoking. This can occur quite early in the smoking career, even within two years. Many young smokers show social, psychological and pharmacological motives to smoke.

Various studies (*18*) have noted that, beyond the preparation and anticipation stage, "the relative influences of the social environment, intrapersonal factors, and physiological reactions may be contingent on the function of smoking for the individual". Research into the various functions of smoking for adolescents postulates three main categories of disposition: social compliers, affect regulators and self-definers. Put simply, the social complier uses the social setting as

a cue to smoke; the affect regulator uses tobacco to help control feelings, as a coping strategy, and the self-definer smokes primarily out of rebellion. One should not, however, assume that these constructs are immutable. An adolescent may exhibit characteristics of all three categories to varying degrees, depending on the situation and developmental stage.

Overall, the social environment is the single most important determinant of smoking onset. Planners of prevention policy and education must therefore take into consideration the elements that comprise this category of influence. Smoking by parents, siblings, peers and older students is associated with an increased risk of smoking initiation by school-age youth. Table 2 lists other important elements or

Table 2. Factors associated with smoking onset

Factor	Reference
Being female	*19*
Living with a lone parent	*19*
Not intending to be in full-time education after the legal school-leaving age	*19*
Having less negative views about smoking	*19*
Feeling alienated from school and the values it represents	*20, 21*
Having ever been drunk	*22, 23*
Having a boy or girl friend	*22, 23*
Having a best friend who smokes[a]	*24*
Knowing at least one cigarette brand[a]	*24*
Having a favourite cigarette brand[a]	*24*
Not knowing or not accepting any of the health risks[a]	*24*
Having at least one parent who smokes[b]	*24*
Positive beliefs about smoking, such as looking grown-up; calming nerves[b]	*24*

[a] More predictive in males.

[b] More predictive in females.

factors that may foster smoking and the references that cite them. A study of people aged 11–15 in the 12 countries of the European Community showed that factors influencing changes in young people's smoking behaviour include smoking by best friend, frequency of alcohol drinking, permissive attitude towards tobacco in parents, visits to discos, amount of pocket money and smoking status of parents (*25*). The study did not find tobacco education at school to be a significant influence.

The relationships between the various internal and external influences on young people to smoke are complex and sometimes disputed. Regardless of the etiological perspective, however, one should recognize that young people are not a homogeneous group. The very individual life experiences and needs of adolescents shape their intentions and actions. All of these change as adolescents grow older.

The design and implementation of preventive programmes need to take account of the varying influences on young people to smoke, while recognizing that education can have only limited impact. Furthering healthy public policy at the local and national levels (by such means as cigarette price increases relative to inflation, advertising and promotion controls, and restrictions on smoking at work and in public) may help to reinforce and boost educational efforts. Such actions address some of the known external influences on young people. Research into the factors that precipitate smoking and the mechanisms that contribute to changes in smoking status should continue, and its results should be widely disseminated.

PREVALENCE OF SMOKING

Most young people in Europe do not smoke, although they will have tried smoking at least once by the age of 15 (*1*). Taking account of different methodological criteria, numerous studies have noted that very few school-age young people smoke regularly. For example, the study of young people in the European Community revealed the prevalence of regular or current (weekly) smokers to be 5% (*25*). Prevalence varied considerably. The total prevalence of regular smoking ranged from 3% in Greece and Italy to 6% in Denmark, France, Germany, the Netherlands and Spain. For all countries,

smoking prevalence increased strongly with age. The prevalence of regular smoking in people aged 11–12 was 0–2%. For people aged 13–15, prevalence ranged from 2% in females in Italy to 12% in males in Germany. Males were more likely to report regular smoking, although females had higher rates in Denmark, Ireland and the United Kingdom (Great Britain). In the Netherlands and Spain, prevalence showed no significant difference by gender (*25*).

The WHO HBSC survey used a broader interpretation of current smoking, including daily, weekly and occasional (less than once a week) smoking (*1*). This led to the recording of higher rates of current tobacco use. Prevalence ranged from 3% to 10% in 11-year-old boys in Austria and Poland, respectively, and from 1% to 5% in girls in Austria and Wales, respectively. By age 15, prevalence ranged from 19% in Wales to 39% in Hungary for males, and from 16% in Poland to 39% in Finland for females. The occasional smokers of the HBSC survey appear to account for a sizeable proportion of the current smoker category in the European Community survey. A comparison of the prevalence of daily smoking in people aged 15–16 years in selected countries during 1985/1986 and 1989/1990 reveals no statistically significant changes (*26*).

Reports from countries note findings as diverse as the methodologies employed. Bearing in mind the immense difficulties of making international comparisons, one can find a few consistencies among the small sample of studies examined:

1. the approximate proportion of nonsmokers up to age 16, including ex-smokers, is 60–70%;
2. females are more likely than males to consider themselves as smokers;
3. where smoking is in decline, the higher socioeconomic groups quit first, and the decrease is in general more marked among males;
4. the prevalence of lifetime smoking and the number of cigarettes per day increase with age;
5. there is a general association between being a current smoker and living in an urban area;

6. the age of smoking onset is in general between 11 and 16 years, although it is as early as age 9 in some areas; and
7. smokeless (oral) tobacco use has increased among Norwegian and Swedish males.

HARM TO YOUNG PEOPLE

The ill health associated with tobacco use is more prevalent in middle-aged and elderly people. Although some young people succumb to tobacco-related diseases, the vast majority of premature deaths related to tobacco results from a long and sustained smoking career; for many smokers, the habit begins in adolescence or even childhood, and becomes firmly entrenched by early adulthood. Nevertheless, some young smokers show some of the health consequences of tobacco use. For example, young smokers are more likely to have bronchitis and other respiratory complaints, coughs, colds and shortness of breath than their nonsmoking peers (*27*). They are also more likely to be absent from school as a result of the health consequences of smoking, and they have an increased risk of using illicit drugs and drinking heavily.

Although the negative effects of smoking are relatively well known, this knowledge has apparently done little to deter the onset of smoking among children and adolescents. The consequences of tobacco use seem remote to young people. The immediate perceived benefits of social cachet, rebellion and the like seem to obscure the spectre of possible future illness and death. As mentioned, the pharmacological effects of nicotine have a huge influence for continued use. Although the rewards of continued smoking are unclear, avoiding the unpleasantness of nicotine withdrawal may be "more important than any positively rewarding effects" (*28*).

CONCLUSIONS

Although there is evidence of a general decline in smoking and an increase in ex-smokers, young people, especially females, are still taking up the habit, despite increased public knowledge of the associated health risk. Although most young people are nonsmokers, there

has been little evidence of a decline in the number who never try smoking. European countries vary widely in the prevalence of daily smoking among young people.

The relationship between the determinants and maintenance of smoking is unclear, but the social environment appears to be especially influential. The long-term nature of tobacco-related illness seems to be an obstacle to achieving the goal of discouraging young people from taking up smoking. In addition to preventive work undertaken in schools and through campaigns aimed at the young, initiatives that target adult tobacco use must be considered. Parental use is a key factor in children's experimentation, so measures that decrease parental use may result in children's growing up in homes and environments where smoking is unacceptable. Measures for both young people and adults include general and targeted education, cessation support, increased taxation and more nonsmoking areas. Because tobacco use by young people is primarily opportunistic, the availability of cigarettes and tobacco products should be restricted. Along with restrictions on advertising and promotion, such measures have been associated with reductions in tobacco consumption by young people in some countries.

4

The School as a Setting for Health Promotion

Diverse interventions have been used to prevent substance use. Measures for young people range from persuasive and educational programmes aimed at influencing attitudes and behaviour, to action aimed at changing the environments of substance use, such as restrictions on the sale and controls on the price of alcohol and tobacco products. Although increasing evidence supports the effectiveness of the environmental approach, the value of preventive work in schools should not be underestimated. Even so, many recognize that efficacious education on substance use cannot be conducted in isolation from wider preventive and health promoting efforts.

The Ottawa Charter for Health Promotion (*29*) defines health promotion as "the process of enabling people to increase control over and to improve their health" and links it to five strategies:

- building healthy public policies
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services towards health promotion and disease prevention.

Any or all of these approaches can be used as a framework to promote not only the general health of students and people in the wider

community, but also the values and attitudes compatible with responsible decisions about substance use.

THE HEALTH PROMOTING SCHOOL

Children learn not only in the classroom but also through everyday experience and interaction with the people around them. For this reason, it is being increasingly recognized that the messages and information on health that are received and practised in the classroom must be reinforced and supported outside it. Problems of credibility are certain to arise when children receive education to prevent smoking, yet smell smoke outside the school staff room or see their parents smoke at home. Young people may become confused, or even angry, if they are given messages about the responsible use of alcohol and other substances, but see few examples of this message in practice.

The recognition of the potential dichotomy between the health promoting messages within the classroom and the not-so-healthy examples outside it gave rise to the concept of the health promoting school. The overall aim of the health promoting school is to achieve (*30*):

> healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. [The concept] offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment.

Collaboration between WHO, the Commission of the European Communities (CEC), the Council of Europe (CE) and other international organizations resulted in the establishment of a network of health promoting schools in participating European countries. This network provides a system for the dissemination of models of good practice. The network operates at several levels, involving management and coordination in schools and within and between countries. A project support centre provides guidelines, coordination, training and information to participating schools in each country. As of June 1995 the network covers 33 countries (Albania, Austria, Belgium (Flemish-speaking and French-speaking regions), Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France,

Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Slovakia, Slovenia, Spain, Sweden, Switzerland, The Former Yugoslav Republic of Macedonia, Ukraine and the United Kingdom) and 5 more (Iceland, Israel, Italy, San Marino and Turkey) are expected to join.

The success of this initiative and the achievement of its goal of healthy and empowered children depend on the "full and sustained support of leaders at all levels in education, health and socioeconomic development" (*30*).

WHO, CEC and CE have identified characteristics towards which participating schools should aspire. They represent ideal conditions, indicating only "the range of possibilities for the promotion of health within a health promoting school" (*31*). The health promoting school (*30*) should:

- *provide a health-promoting environment* for working and learning through its buildings, play areas, catering facilities, safety measures, etc.;
- *promote individual, family and community responsibility for health*;
- *encourage healthy lifestyles* and present a realistic and attractive range of health choices for schoolchildren and staff;
- *enable all pupils to fulfil their physical, psychological and social potential* and promote self-esteem;
- *set out clear aims* for the promotion of health and safety for the whole school community (schoolchildren and adults);
- *foster good staff–pupil and pupil–pupil relationships* and good links between the school, the home and the community;
- *exploit the availability of community resources* to support action for the promotion of health;
- *plan a coherent health education curriculum* with educational methods that actively engage pupils;

- *equip pupils with the knowledge and skills* they need both to make sound decisions about their personal health and to preserve and improve a safe and healthy physical environment; and
- *take a wide view of school health services* as an educational resource that can help pupils become effective health care consumers.

Three main strands in the health promoting school are the health education curriculum, the hidden curriculum and the health and caring services. Each has its own important place in the provision of health education.

The Health Education Curriculum

Health education can appear in the curriculum in a number of ways: as a distinct element in the curriculum with its own designated time, as an essential element in other subjects in the curriculum, or when teachers use opportunities as they arise (*32*). Education to prevent substance use is amenable to any of these curricular approaches, but should ideally be set in the context of other issues that are important to students.

Materials are increasingly being designed for use not only in health education, but also in other subjects and as the need arises. It is not necessary, however, to rely on a shelf full of resources and packages. There are numerous ways to educate students about substance use and to empower them with skills for use now and later in life. For example, creative and aesthetic subjects may offer scope for acting out a situation in which drugs are offered, or for inventing recipes for nonalcoholic drinks and designing an advertising campaign for the one voted by students and teachers as the most likely to appeal to those who like alcohol. Opportunities to broach the subject can arise from the pages of the local newspaper or as a response to misinformation circulating in the school playground. Some areas may have an awareness campaign, on sensible drinking perhaps, to which school health education may be linked. Connecting with and supporting wider health promotion efforts are good ways not only to reinforce the message but also to make optimal use of limited resources. The chances to integrate health education into most areas of the curriculum are endless, limited only by the imagination of teachers and

students. Even so, one should remember that formal education is but one of myriad influences on attitudes towards and the use of alcohol and other substances.

The knowledge and techniques of teaching staff should be updated to reflect changes in the understanding of the etiology and epidemiology of substance use, as well as of issues and approaches in prevention. Outside agencies can be invaluable to this process.

The Hidden Curriculum

The hidden curriculum has been defined as (*33*):

> the whole ethos established by the atmosphere of the school, its code of discipline, the prevailing standards of behaviour, the attitudes adopted by staff towards pupils, and the values implicitly asserted by its mode of operation.

This view recognizes that the interactions of staff with students and with each other are a powerful influence (*32*):

> Standards, attitudes, values and ways of behaving have a profound effect on pupils' social development. That this is the case should be recognized by the school.

Students notice not only whether the behaviour of staff is congruent with that expected of students but also courtesies, concern, tolerance, and the physical state of the school and the types of food available in the canteen. All of these affect the development of students' self-esteem. The school should make every effort to convey concern about all of its students and to create opportunities, in both the formal and informal curricula, for developing caring and responsible attitudes in its students. To this end, teachers should encourage students further to develop their social skills and to take responsibility for their actions and decisions. Students can practise these skills in the classroom by taking responsibility for some of their own learning, including setting personal goals, and by interacting with adults visiting the school and with community groups that use the school premises, such as mother and baby groups and elderly people. In addition, involvement in community service is also a way of developing a sense of self-worth and responsibility in young people. These

personal characteristics have been linked to avoiding substance use and other health-damaging behaviour.

Adolescents often seek out new experiences and take risks. For some young people, experimentation with alcohol, tobacco and other substances is a part of growing up. The school can provide a positive outlet for young people's need for stimulating experiences by offering a choice of enjoyable activities, which can include anything from painting, music and drama, to cultural exchanges, field trips and rock climbing. Thrill seeking, however, is only one of the many reasons why young people use alcohol and other substances.

Although schools cannot be expected to prevent all substance use by students, they can adopt and implement firm policies that make clear their position on substance use on school premises. Schools should have equivalent policies for staff members. A positive statement of the school's ethos, stressing the importance of the school community and relationships between staff and students, should accompany the necessary list of prohibited behaviour. Many schools have found this combination to be helpful.

In addition to caring about the health and welfare of students, the health promoting school also promotes the health of staff. Senior managers in schools have a responsibility to create, as far as they are able, the physical and psychological conditions that allow staff to perform well. A structured system of support should be available to all staff throughout the school (see Chapter 6).

The Health and Caring Services

The health and caring services affiliated with the school are important. They can provide not only necessary screening and immunization but also further support to the school's health promotion programme. The specialist knowledge and skills of health professionals can be used to increase the motivation and understanding of students, parents and staff in relation to health-related issues.

Various pilot programmes have been conducted in the European Region to increase the links between schools and health services. These programmes include preparatory lessons by teachers on the purpose and methods of an upcoming medical examination. While the

students await the examination, they play related educational games; students are often provided with a card on which to record their visits to health services and the results. When students return to the classroom, the teacher gives follow-up lessons to demystify the role of the health care provider, as well as to answer any questions about the examination. The aim of such programmes is often to enable students to feel more in charge of their health.

Less elaborate and ambitious links can prove just as valuable. Presentations by doctors and nurses on various aspects of substance use can be integrated into a planned programme of health education. In addition to their traditional duties, the school's psychological services can provide training for teachers and run workshops for parents on drug use.

RELATIONSHIPS WITH THE COMMUNITY

The notion of using schools as a setting for promoting health in communities is a relatively recent one. Although the school has long been recognized as a proper setting for providing young people with health education and, more recently, for shaping their values, attitudes and behaviour, it is just now being seen as a tool to empower staff, parents, family and the wider community. The school is also increasingly noted as a means to link students with outside resources that may enhance their health and wellbeing (*32*).

> The establishment of a health promoting school depends for its success on each of the partners in the home–school–community relationship playing its part. Personal development takes place to a large extent in a social context with other people, within human relationships. Our own personal development is bound up not only with the improvement of the quality of our own lives but also the lives of those around us.

Community service helps to fulfil this objective by showing students not only how the local community provides care but also how they can positively affect the lives of the people around them. It is hoped that, by working to help others, students will gain self-confidence and self-awareness. Although young people can acquire these attributes inside or outside the school, the encouragement of such links with the community sends a clear message to students,

parents and others about the relationship between the school and the community.

Aside from helping students to acquire skills and attributes that will prepare them for adulthood, the school can provide practical support to others in the community. Many schools are not just for students. Outside of school hours, buildings can provide meeting space for community groups; groups and individuals can use the sporting facilities and health fairs, displays and theatrics can inform, entertain and spark action within the community. There are many excellent examples of this type of link between the school and the community.

Strategy for Intersectoral Cooperation in Germany

The Bundesverband der Betriebskrankenkassen, the head association of occupational sickness insurance funds in Germany, suggested that a panel discussion be held on the theme of "drug prevention: different approaches – common responsibility". This emphasized that handling tasks in this field can require multidisciplinary action and networking. In practical terms, all institutions in the health and education sectors must identify their particular approaches and work together to prevent substance use by young people.

Intersectoral Cooperation in Denmark

In the beginning of the 1990s, the Danish Council on Smoking and Health, in cooperation with the Danish Cancer Society and Danish Heart Foundation, introduced a campaign called "When education goes up in smoke". The campaign focuses on the smoking policies of all primary and lower secondary schools. The short-term aim is to provoke debate on policies on and habits of smoking in both teachers and pupils. The long-term aim is that schools should adopt a smoking policy that does not allow pupils to smoke at school, and permits staff to smoke only in staff rooms.

Past and Proposed Action in Schools in Copenhagen

The Copenhagen Health Services' campaign on alcohol in 1991/1992 showed that placing two buses at the disposal of students to produce theatrical shows and videos was a great success. Many of the participating schools stated that, in addition to the exchange of facts, this method had strengthened the students' confidence, self-esteem and

feeling of community in classes. Based on this experience, the Copenhagen Health Services (*34*) proposed that "during a period of three years attempts will be made to establish a 'Healthy Bus Project', to help schools to create theatrical shows focusing on one or more health subjects".

Such a bus is thought necessary because younger students appear to respond more readily to shows than to videos. A media bus for older students is already in operation. During the school holidays, the buses would be available to recreation centres and city youth clubs. In addition, the project would support existing campaigns so that, during periods when specific health issues (such as smoking or drug use) are in focus, classes wishing to address the issues can use the bus facilities. Everyone involved recognizes that mobile facilities of this type are a useful tool in prevention education.

Community-based Action in Finland

A project team, and staff from schools, libraries and outpatient clinics, organized an event called "Liquor Week" for the city of Lahti. The main public library was the scene of a display of reading materials on alcohol and drug use, and other consumer, health and cultural issues, tasting demonstrations, plays, lectures and videos. The aim was to use existing materials to present information on alcohol and drugs in a way that was entertaining, nonjudgemental and relevant to the audience.

The library is a very important institution in Finland, providing both information and entertainment. About 70% of the population uses a library. It was felt that the main library would be a neutral venue in which to reach the population of the city. The organizers, including school staff, brought to the event their own skills and expertise.

Over 60 000 people visited the library during the event, taking 40 000 leaflets, or about 1 per family. Of the leaflets taken, about one third related to leisure or consumer issues and two thirds addressed health issues.

WORKING WITH OTHER AGENCIES

Liaison with the community need not be limited to the sharing of facilities. Ideally there should be a mechanism through which schools and other local bodies exchange ideas and information. In many areas and cities, departments of education are represented on intersectoral groups and commissions.

Education about health is not the exclusive task of the department of education. Many other agencies have an interest in or even a responsibility for educating people about health and substance use. Intersectoral links help to avoid duplication or conflicting messages, as well as increase awareness of prevention efforts undertaken by the school. Such links also allow other agencies to participate in school and school/community initiatives.

Teachers possess specialized knowledge and experience that can help to inform and influence the health-related work of other professionals. Conversely, other agencies can usefully contribute their expertise to school and community initiatives and developments. This is especially true in dealing with issues related to substance use, when specialist knowledge and guidance from drug prevention agencies, the police and researchers can be extremely useful. In addition, the mass media can be used to publicize school-based and school/community prevention initiatives. One department of education (*35*) collaborates with outside organizations and agencies by:

- inviting representatives from other agencies to join its committees and working groups, and being represented on those of other agencies;
- developing collaboration not only between management representatives but also among practitioners;
- cooperating with and initiating research and evaluations;
- jointly funding ventures such as theatre workshops and relevant staff training courses;
- taking part in national and local initiatives related to, for example, drug prevention weeks, World AIDS Day and smoke-free generation clubs;

- inviting other agencies to contribute to or take part in staff training, reciprocating in other agencies' training, conducting joint training and developing multidisciplinary training;
- publicizing and sharing good practice in preventing substance use through work with community groups, schools and special projects; and
- actively looking for ways to promote joint work at all levels.

Outside bodies, too, should be encouraged to share their resources and expertise in a direct way. Examples of this include drama-based workshops that encourage students to explore issues surrounding HIV/AIDS, a business-sponsored essay contest on the theme of alternatives to drug use, and a mobile multimedia presentation on responsible alcohol use. Although the focus and themes related to substance use and its prevention vary, the means of highlighting them are often useful in a number of situations.

RELATIONSHIPS WITH PARENTS

The health promoting school also endeavours to involve parents in educating their children about health and social issues. Most parents acknowledge that they have the primary responsibility for the health and welfare of their children, but they often appreciate the role that the school plays in this area. The school and parents should be partners. Parents must therefore understand the philosophy, the scope and the organization of health education at school and the need for open communication with their children and the school about the children's health. Meetings, leaflets, videos and other means can be used to educate and inform parents not only on how the school views and provides health education but also on specific health issues, such as parents' smoking and their children's health. Such communication may also give scope for parents to be involved in the development of school policy.

It is becoming increasingly common for schools to provide information to parents about issues that affect their and their children's health. There are many excellent examples throughout the European Region of this approach. The purpose of such information is often to

raise awareness of the impact that certain health behaviour has on children. For example, leaflets sent to parents about children's use of alcohol may include information not only on why some children use it and how parents can discuss alcohol with their children, but also on the influence of parents' drinking behaviour and attitudes on their children. Parents' meetings have the advantage of face-to-face discussion but, as with much extracurricular involvement, they tend to attract the parents who are least likely to need assistance in communicating with their children. Regardless of the chosen method of contact, information and guidelines should be nonjudgemental. Ways of involving parents in the life of the school include (*36*):

- a parents' council, which can provide general involvement and a link between the school and parents and the community;
- activities to raise awareness, such as surveys, discussion evenings and other events;
- newsletters, which inform and update parents on general topics and issues related to substance use and the school's prevention activities;
- open days and excursions for parents, teachers and students;
- making a list of parents with specialized skills and knowledge on substance use and other health-related topics and using them as advisers;
- advice to parents on courses available in local colleges and universities on health-related topics, communication skills and other relevant subjects;
- giving parents access to books, audiovisual equipment and leaflets on health and communication topics; and
- homework that requires parental participation.

In addition, some programmes use training to support the family's role in socializing children. Such programmes focus on parent–child communication, stressing the importance of encouragement, emotional closeness and high expectations (*37*). A study of prevention programmes found that those that build family relationships are some of the most effective in deterring substance use (*38*).

The role of the school should be to help students to clarify their attitudes and understand the values that shape health choices. In doing so, the school staff need to be aware of the range of values that are likely to be held in the community. Parents should have the opportunity to express their views on all educational matters but especially those, such as substance use, that have moral, ethical, cultural and religious implications. Even so, students are bound to raise controversial topics and ethical issues, and avoiding constructive discussion in the classroom increases the likelihood that students will seek answers from peers and the mass media.

The school has a powerful influence on young people. To some extent, it is expected to take the lead in championing values and attitudes that are idealized, but not always adhered to, in society. Nevertheless, one should remember that the school is only one of many complex influences that can affect the health and wellbeing of students. The family, peers, the media and political and social circumstances all contribute to the values and attitudes that help to influence health choices.

CONCLUSIONS

Because of the myriad interdependent influences that shape the attitudes and behaviour of young people, the health promoting messages that are given and practised in the classroom must be reinforced and supported in the rest of the school and in the wider community. The school is therefore increasingly used as a setting for promoting the health not only of students but also of staff, parents, families and the community at large. When staff have expertise in health education, the school frequently has a role in the education of community members about health-related issues. It can play this role in a variety of creative and thought-provoking ways.

The active involvement of young people in school and community life is a key feature of the health promoting school. Young people who can participate and take responsibilities both within school and in the wider community are far less likely to engage in substance use and other health-damaging behaviour.

The formal curriculum plays a small but vital role in the personal and social development of young people. To increase the potential for effective preventive work, schools should form alliances with community organizations, and these allies should work together to benefit the present and future health of young people. Relationships between the school and the community should be encouraged and strengthened.

Address

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5

Education in Schools

The implementation in schools of education programmes on substances varies widely. Programmes differ in approaches, content, target groups, the quality of implementation and usefulness. Many of the differences are due not only to ideology (such as abstinence versus moderation or disease model versus social and environmental model) and emphasis (such as alcohol only, all substances or no particular substance), but also levels of commitment by government and other relevant bodies (shown by contributions of resources and guidelines). Regardless of these differences, many recognize that a comprehensive strategy on substance use is needed in primary and secondary schools. Along with a policy on substance use and a commitment to community involvement, such a strategy ideally includes substance use education as an implicit or explicit feature of the school curriculum. The overall policy of the school on preventive education and substance use must be unambiguous, and should be cohesive in its ethos and application. For example, classroom work, linked community and school activities, and policies on staff and student use of tobacco, drugs and alcohol should mutually reflect and support the school policy. This will enhance the credibility of the policy and compliance by staff and students.

Although schools do much to prevent substance use, there is comparatively little published research that documents such programmes and initiatives. Owing to language barriers, some published reports are relatively inaccessible. The documentation and dissemination of experience in this important area are vital if more is to be learned about creating and implementing successful education programmes to prevent substance use by young people.

CURRENT APPROACHES

School-based educational efforts use a variety of approaches to reach young people. Bearing in mind that concepts of prevention vary in location and content and with the experiences of the target group, much of education on substances seems to focus on the provision of facts and the exploration of personal, peer and societal values for and attitudes towards alcohol, tobacco and drugs. Unfortunately, numerous methodologically sound studies have concluded that many of the approaches and programmes have been ineffective in influencing substance use. Some have even been shown to increase experimentation (*39,40*). Some promising approaches and programmes, however, have been implemented in the European Region.

Many of the newer programmes do not specifically focus on substances. Instead, they take a more holistic view, and emphasize the personal and social development of students. Issues such as drug and alcohol use, HIV/AIDS, sexuality and personal safety are used to illustrate the application of this approach in the way most relevant to the students. In such programmes, the students often define the issues that concern them, with a teacher or peer acting as facilitator rather than instructor. The students explore these issues by expressing their talents and interests in theatre, music and other arts. Such approaches emphasize self-esteem, life skills, information (factual and affective) appropriate to the age group, and the use of peer leaders.

Factual Approaches

Most of the truly negative evaluation findings concern programmes that focus almost exclusively on describing and warning of the future dangers of substance use: so-called facts-only programmes. This approach has been severely criticized in the literature for its ineffectiveness at increasing anything other than mainly short-term knowledge. Knowledge about alcohol, tobacco and other substances, however, can be low even among users, so appropriate education can be useful. The facts-only approach assumes that the target group is unaware of the possible consequences of using a given substance, and will adjust its attitudes and intended behaviour when provided with the correct information. No empirical evidence supports this simplistic causal link. Facts-only programmes and resources frequently fail to take account of the social and cultural influences on the target group or of

personal factors, such as whether some young people are already experimenting.

The more common factual approach involves eliciting students' knowledge and beliefs about substances through structured discussions. This approach often focuses on the short-term and social consequences of substance use. Videos, lectures and films are used to initiate or otherwise complement the discussions and activities. Evaluations of this approach in the United States of America have had very mixed results, although none has demonstrated an increase in substance use.

In a review of drug education in schools in North America, Goodstadt (*41*) concluded that:

> knowledge can be influenced relatively easily, but that such change, while perhaps necessary, is not sufficient to prevent the undesirable behavior, that attitudes are more difficult to influence and are seldom correlated with the behavior in question, and that behavior is the component that has proven to be the most difficult to influence.

Some good, balanced, fact-based programmes and resources are found in Europe, but one should probably not expect them to influence attitudes and behaviour in the long term. Although information alone is insufficient for prevention, its ancillary benefits are not known. Information appropriate to the age group is often part of more complementary, affective and skills-based programmes.

Affective and Skills-based Approaches

Unlike the facts-only approach that focuses on the substance itself, the life skills, social skills and social influence approaches centre on the individual and how he or she communicates and negotiates with others. These approaches are designed to encourage self-esteem and responsible decision-making, as well as to enrich the personal and social development of the target group (adolescents). They share a compensatory perspective that explains alcohol, tobacco and drug use as arising from a deficiency in some essential personal and/or social trait or ability. The theory of social stress supports this view by noting that adolescents use these substances as a means of coping with a variety of stressors (family, school, peer group or community).

According to this theory, adolescents who develop adequate personal and social competence have a reduced risk of substance use.

Experiential learning is a key component. Despite the ubiquity of the affective approach, evaluation studies have largely been unable to demonstrate an effect on intended or actual substance use. Some programmes, however, affect attitudes. Nearly all the evaluated programmes that have a factual component demonstrate an impact on knowledge. Unfortunately, very little is known about the efficacious components of a successful resource or programme. The literature is poor in evaluations, however, so it is difficult to say whether a particular approach or programme influences intended or actual behaviour. Even so, the life skills approach in particular is the basis for many effective and well respected health education programmes across the European Region.

As applied to substance use, the life skills approach promotes self-examination of needs or values and of the various roles that substance use serves in fulfilling them. The objective is to decrease the likelihood of substance-related problems through the promotion of self-understanding and responsible decision-making (*42*). In general, this approach includes cognitive, affective and behavioural components, although information is not a strong feature. Skills such as decision-making and self-assertion are taught as rational responses to particular situations in life. The process of making a decision receives strong emphasis. Lectures, discussions about options, simulations and role playing demonstrate the process and the consequences of decisions. Active, experiential methods and group work are therefore key components of this approach. Davies & Coggans (*43*), however, warn that:

> without careful handling, 'decision-making' sessions essential in the empowerment of young people and the development of positive health behaviour can degenerate into 'decision-implementation' sessions, with the decision being supplied by the teacher.

Adolescents can apply the skills that are taught through this approach in many different situations. The core set of skills is taught and practised in many European schools, although the skills needed may vary according to the gender and culture of the people using them. These skills include decision-making, problem solving, creative

and critical thinking, effective communication, personal relationship skills, self-awareness, empathy and coping with emotions and stress (*44*).

Although the development of life skills is extremely important in the promotion of health in general, little empirical evidence supports the efficacy of this approach on its own in preventing substance use. Perhaps the skills and features on which it focuses find little support in the etiological literature, and have not shown consistent effects on substance use. Nevertheless, it is probably still too early to determine the long-term impact of the approach on attitudes and behaviour, although it almost certainly enhances any substance prevention programme. Regardless of whether the approach affects behaviour, any skills that enable adolescents to exert greater control over their lives can only be beneficial.

The social skills approach has yielded mixed results. It is based on the assumption that adolescents use substances because they lack appropriate psychosocial skills. Three features mark this approach:

- modelling health promoting behaviour;
- learning skills to resist social influences (mainly of peers) that promote substance use; and
- acquiring more general life skills.

This approach therefore mixes general skills and peer resistance skills. Although some empirical evidence suggests that these are correlates of substance use, there is little to indicate how these influences operate.

As applied to substance use, the social influence approaches are based on the recognition that peer, family and environmental influences play an important role in the initiation and maintenance of substance use. The most common form is the peer resistance approach (*45*):

> In general, these approaches involve (1) making students aware of the social influences promoting use that they might be exposed to, (2)

teaching specific skills (such as refusal skills) with which to resist these influences, and (3) correcting misperceptions of social norms regarding use.

Most of the research on this approach examined work to prevent smoking by adolescents (*46*). The idea was to inoculate young people against pressures to smoke. Current applications of this approach emphasize training students to deal with both peer and media pressures to use various substances.

This group of approaches recognizes that even the most competent adolescent may need help to say "no". Two distinguishing features are the use of peer leaders, and of role-playing and social reinforcement to teach refusal skills. Both features are used to create a climate in which saying "no" is the easiest thing to do. Programme elements include providing information and encouraging skills in decision-making, resistance, norm setting and critical analysis (particularly of messages from the mass media).

Although these approaches have focused most successfully on preventing or delaying the onset of smoking, a study by McAlister et al. (*47*) demonstrated a positive impact on alcohol and marijuana use as well. A nonprescriptive version of this approach that stressed the social influences of alcohol use yielded mildly encouraging behavioural results when evaluated in England, Wales and Scotland (*48*). Other studies have demonstrated a positive impact on knowledge, attitudes, beliefs and social resistance skills (*49,50*).

These approaches appear to be the only ones that have anything beyond a short-term effect on behaviour, although the variability of programme content and delivery means that the efficacious elements have not been identified. In addition, the effectiveness of these approaches with young people at high risk or with minorities is unknown. Booster sessions in subsequent years are sometimes provided to reinforce programme effects. In at least one study, activities and booster sessions led by peers have proved more effective in reducing the likelihood of alcohol, tobacco and marijuana use than those led by teachers (*51*).

In general, meta-analyses support the view (*52*) that:

the most efficacious program for reducing drug abuse is a program that features social influences resistance training as a major focus.

One should remember, however, four important points.

1. The success rates for evaluated programmes are relatively low.
2. In general, success is defined in relation to a short-term follow-up: up to two years but as little as three months.
3. The emphasis on negative peer pressure may be based on erroneous assumptions about the relationship between social cognition and social behaviour. The social influence approaches do not acknowledge that adolescents choose friends who are most like themselves. Such groups are as likely to exert positive pressure as negative.
4. Again the most or least effective programme components and the most effective providers cannot be determined (*51*).

Nevertheless, the use of peer leaders (the same age as or older than the target group) is widely assumed to play an important role in programmes of this type. Most such programmes have this feature and many studies have supported it, although peer leaders are mainly used in an ancillary fashion and may be more influential with females than males. Programmes using social influence techniques appear to be coming into more widespread use.

Multidimensional Approach

Various educational approaches on alcohol, tobacco and drugs are being used in schools across the European Region. Much of this work incorporates not only factual knowledge, but also skills and attributes that enhance the personal and social development of students. The literature is often contradictory in identifying the elements in school-based programmes that may influence knowledge, attitudes and behaviour; research findings are very specific to the programmes studied. The influence of internal and external factors on attitudes and behaviour related to substance use limits the scope and expectations of school-based intervention. Even so, a recent review by Hansen (*53*) concluded that the most promising programmes were those that used a number of different strategies.

Of the 45 evaluation reports studied, Hansen identified 6 groups of programmes that used 1 or more of 12 specific prevention strategies (*53*). Comprehensive and social influence programmes were found to be the most successful in preventing the onset of substance use. The components identified in the social influence programmes included resistance skills training, information, pledges not to use substances, and norm setting. The comprehensive programmes on average featured seven different components in various combinations. All of the comprehensive programmes included information and training in decision-making and resistance skills. When components of each programme type operated in isolation, behavioural outcomes were mixed at best. The individual elements of each positively evaluated programme varied enormously. Combining various strategies and methodologies seems to increase the likelihood of achieving the desired effects. Norman & Turner (*54*) note, "there is not as yet a consensus as to which multiple strategies in what combinations, are the most effective for which groups of youngsters".

CONCLUSIONS

Despite the uncertainty about influences on substance-related attitudes and behaviour, some elements have demonstrated an impact: peer-led sessions and skill-based learning. Adolescents' active participation in their own learning is a key feature in most successful programmes. In addition, programmes that address the social influences on young people's attitudes and behaviour have demonstrated positive outcomes. The combination of information (on substances and social influences on their use) and specific skills to resist inappropriate use appear to be at least partially instrumental in the success of some programmes. Regardless of the combination of strategies that schools use on substances, the most promising overall strategy appears:

- to be part of an overall health education and health promotion programme, and centred on the students;
- to use a variety of methods;
- to emphasize the present, not the future; and

- to take account of the personal, psychological, cultural, social, parental and other factors that influence attitudes and behaviour (see the list given in Chapter 1 in relation to alcohol use).

In addition, a programme is believed to be more likely to influence students' attitudes and behaviour if it:

- has a message and a messenger that are credible and appropriate to the target group;
- is nonjudgemental but consonant with existing public opinion and attitudes;
- requires active rather than passive participation;
- is appropriate for students of different abilities and/or cultural backgrounds;
- has appropriate goals and expectations and sufficient duration and intensity;
- is supplemented by continuous and multilevel reinforcement of the message in the school, and by revisitation and adaptation of the message at key points in the students' school career;
- provides adequate training and support for the teachers or facilitators involved;
- is properly implemented; and
- interests or involves parents.

Table 3 summarizes the components of preventive programmes in schools as noted by Hansen (*53*).

In addition to the methods listed in Table 3, those listed below are used in various combinations in many innovative school-based programmes across the European Region. The list is by no means exhaustive; programmes in many countries and areas use methods specific to their culture and prevention ideology. These methods can be used in most areas of the school curriculum. Ideally, all teachers should do preventive work in either a planned or opportunistic way, particularly if no time has yet been allotted to health education.

Table 3. Components of preventive programmes in schools

Component	Aim	Format of delivery
Information	To target knowledge and beliefs about substances	Lectures, films, discussions, debates, books
Training on decision-making	To teach a process for making rational decisions about substance use	Lectures, discussions, work sheets, role play
Pledge	To make a statement of personal commitment not to use substances, often within a moral context	Oral or written statement, wearing of a badge
Values clarification	To examine personal values related to substances, and to demonstrate the incompatibility of substance use with these values	Group discussions, work sheets
Training in goal setting	To develop skills in goal setting and to encourage their achievement	Didactic instruction, work sheets, out-of-class projects, self-monitoring of class performance
Training in stress management	To teach coping skills, with special emphasis on relaxation techniques	Didactic instruction, discussions, work sheets, practising of skills
Training in self-esteem	To develop feelings of self-worth and value	Work sheets, discussions
Training in resistance skills	To teach skills for identifying and resisting peer and other influences (from advertising, parents and siblings) to use substances	Films, discussions, role playing, assertiveness training
Training in life skills	To develop broad social skills and skills in conflict resolution	Lectures, discussions, role play, practising of skills

Table 3 (contd)

Component	Aim	Format of delivery
Training in norm setting	To establish norms on substance use by correcting misperceptions of its prevalence in and acceptability to peers	Surveys, games, discussions, debates, use of peer leaders, testimonials
Peer assistance	Intervention and counselling by students the same age as or older than the target group	Peer-led discussions in the classroom, peer assistance and referral outside the classroom
Alternatives	To offer creative or physically challenging activities incompatible with substance use and/or an attractive alternative to substance use	

Source: Hansen (*53*).

Useful methods include:

- discussion by classes and smaller groups (with feedback from groups to the class);
- surveys and other investigative work;
- written exercises, including homework with parents but also advertisements or jingles, stories, plays and newspaper articles;
- research in the library;
- drawing, graphic design and making videos;
- brainstorming
- flash cards (with younger students);
- calculations of substance use and the harm related to it;
- mixing and tasting nonalcoholic drinks;
- visits from experts such as police officers, doctors and drug workers, followed by discussion; and
- performing original creative works to other classes and schools.

Areas of the school curriculum in which education to prevent substance use can take place include: health education, personal and social education, native language studies, the arts, religious and moral education, science (biology, chemistry), mathematics, citizenship, physical education, environmental studies, history, cultural studies and sociology, economics and politics.

This section concludes with an example of a comprehensively implemented peer education programme.

FIT 2001 – Club for the Third Millenium: Peer Programme for Schools in the Czech Republic

In 1993, the Czech Ministry of Education, Youth and Sport asked the Prague Psychiatric Centre, the Prague Psychiatric Hospital, the National Centre for Health Promotion, Prague and the Pedagogical Research Institute, Prague to develop a model preventive programme based on the principles and current examples of peer leadership. The developers of the programme (K. Nespor, L. Csémy and H. Pernicova) consulted key people in Norway and the United States who had experience in designing and implementing peer-led programmes. Guided by findings from a recent survey of knowledge of, attitudes towards and use of substances in schools, the Czech programme was pilot-tested in four Prague schools. Peer education in various forms had been taking place with adults and children since 1990 through the FIT IN programme (55,56).

Teachers from each of the four participating primary schools worked with the programme developers to motivate and recruit suitable future peer leaders (with an average age of 13) and to train the students in the four-hour programme. Concurrently, a booklet about the programme was given to all parents. The trained peer leaders then delivered the programme to slightly younger students. To obtain feedback from the children, a short follow-up questionnaire was administered at the end of the programme.

The first hour of the programme addressed motivation, describing the advantages of good health and a smoke-free, sober and drug-free life, and how a healthy lifestyle is helpful in achieving personal goals. The methods included small groups, brainstorming, making posters and a question-and-answer session.

The second hour presented positive alternatives to substance use. The leaders stressed the importance of relaxation and physical exercise, indicated where to seek help for various problems, addressed problem solving techniques and introduced relaxation training.

The third hour focused on refusal skills. This included avoiding dangerous situations, and various types of refusal of alcohol, tobacco and drugs. These comprised quick refusals (ignoring an offer, gesturing, simply saying "no"), polite refusals (giving an explanation, offering something better, changing the topic, postponing the issue), rude refusals ("the parrot" – repeating the refusing phrase again and again – and refusal with counterattack) and "regal refusals" (refusing once and for all, and refusing in order to protect one's own health while urging the other person to do the same).

The fourth hour was devoted to reinforcement. This included advertisements and how to resist them, creating an original advertisement to promote healthy lifestyles, and the advantages of a sober, drug-free society. A question-and-answer session, the presentation of diplomas to the participants and the ceremonial closure of the session followed.

The training of the peer leaders followed the same format but the programme developers also emphasized communication skills, such as using a strong voice and eye contact, and facilitating a discussion of controversial topics.

Following the pilot programme, each participating school had a number of trained peer leaders and a teacher familiar with the programme. This enabled the schools to be self-sufficient in prevention work for years to come. A handbook for peer leaders is planned for use by future peer educators. Topics for inclusion are: information about addictive substances, steroids and gambling, positive alternatives (including healthy lifestyle, relaxation and yoga), problem solving, refusal and social skills, traffic safety, how to analyse and resist advertisements, effective communication, and the social aspects of substance-related problems.

Although FIT 2001 had no formal process or outcome evaluation, the feedback from students and teachers was very positive. Some

teachers even applied its principles in other work. The results from the follow-up questionnaire indicated that the topics students found most useful were refusal skills, and information on the risks of alcohol and drug use and healthy lifestyles. The students said that they particularly enjoyed the physical exercises and relaxation, drawing, role playing and group activities. The programme developers (*57*) concluded that the programme was "successfully structured, combining transmission of important skills and attitudes with activities enjoyable and attractive for children". The experiences of the pilot group support earlier findings on the effectiveness of peer-led education (*50*).

6

Policies for Developing Prevention in Schools

The role of the school in the prevention of harm from substance use has broadened as more has become known about influences on young people to use alcohol, tobacco and drugs. The necessity of a comprehensive approach to prevention, using a variety of strategies, is increasingly recognized. Along with school health education and community participation, a school's policy and procedures may help to prevent the harm from substance use by students. This section is based on an exemplary guideline document entitled *Developing a school drug policy and school response to incidents of drug use* (58).

An effective school policy should try to prevent problems related to substance use by:

- identifying the content of the health education curriculum that staff, parents and students perceive as important and relevant;
- ensuring that health education is provided, with adequate resources;
- providing, when necessary, professional development for the teachers involved;
- ensuring that health education has adequate time on the school schedule.

In addition to providing appropriate education on substance use, schools should acknowledge that students may use substances at school. Procedures should be in place to deal with such incidents

adequately and consistently. All staff, students and parents should be familiar with the procedures. The school needs to vary its responses according to the type of incident, such as suspected drug use, witnessed drug use and a medical emergency.

A school policy on substance use offers a number of advantages:

1. it reinforces the school's role in the prevention of substance use problems;
2. it clarifies the roles, rights and responsibilities of each member of the school community in substance use problems, prevention and intervention;
3. it sets guidelines for students, staff and visitors on acceptable behaviour related to substance use in school;
4. it ensures that school staff do not put themselves at risk by their actions through a clear statement of the school's legal and procedural responsibilities;
5. it provides a standardized approach to an often controversial and emotional issue;
6. it identifies a sequence of events that will take place when an incident involving substance use occurs, which should incorporate appropriate and fair disciplinary measures and stipulate when parents and/or the police should be notified (although schools in some countries are bound by law to notify the police about the possession or use of particular substances);
7. it protects the welfare of students and staff by ensuring that incidents are addressed rationally, and by ensuring confidentiality and access to counselling if necessary; and
8. it supports staff by relieving them of the sole responsibility for making decisions when incidents occur.

DEVELOPING POLICY AND PROCEDURES

The process of developing the policy and procedures can be as important as the policy itself. The policy must be carefully thought out in consultation with the people whom it will affect: staff, parents and

students or their representatives. Consultation increases the likelihood that the school community will respect and adhere to the policy. Although each school has its own agenda and issues, it is desirable that policy development take six steps.

First, the school should form a temporary committee that represents the views of the school community (including students). The committee should make recommendations on the policy's content, establish a standardized response to incidents involving substance use, develop and disseminate the draft version and prepare the final document.

Second, the school should organize a workshop to provide the committee members with up-to-date information on issues in substance use by young people. Staff, parents and community members may find the workshop useful, particularly in raising awareness of the advantages of a school policy.

Third, the school should conduct a needs assessment analysis and identify any current or potential problems with substance use, as well as local resources available for support or intervention, such as the police, drug and alcohol units, and health workers. The school should also review its current policy and ask other schools with a similar demographic profile to supply further examples.

Fourth, the school should write the draft policy, detailing not only the proposed interventions but also the preventive initiatives that will complement and support the school policy. The draft document should be circulated for comment to committee members, school staff, their union representatives (if relevant), parents and the local health promotion unit.

Fifth, the school should give adequate notice to all in the school community of the date when the policy will come into effect. If appropriate, the school should provide support to people who will need to adjust their lifestyles. For example, it could provide smokers with information and help on cutting down.

Sixth, once the policy and procedures have been implemented for a designated amount of time (such as a term), the school should re-

convene the original committee to assess the policy's effectiveness. A survey or anonymous written comments are two common ways of quickly gauging acceptability and compliance.

Some important issues should be considered in the making of a school policy:

1. What are the reasons for developing the policy?
2. Will the policy address both prevention and intervention?
3. Will it apply equally to students, staff and visitors?
4. Will there be any differences by substance or context of use in the application of the policy?
5. Will the policy cover substance use at functions held on school premises?
6. Are there policies and regulations, such as national drug control legislation, with which the proposed policy should comply?
7. Will the policy cover the use of all types of drugs, licit and illicit?
8. Will the staff be offered an in-service briefing prior to implementation?
9. How widely will the policy document be disseminated?
10. What will be the mechanism for informing new students and staff, as well as visitors to the school, about the policy?
11. Will the policy be reviewed and, if so, when and by whom?
12. How will the issue of confidentiality be addressed?
13. What types of intervention will be used, and will they differ according to the situation (such as possession only, use and dealing)?
14. Will there be different interventions or disciplinary procedures for staff or students who come forward with substance use problems or concerns?

In addition, some questions about school responses to incidents of substance use should be answered.

1. Will the proposed intervention procedure protect the welfare and privacy of students while being consistent with the school's ethos and operation?
2. When and how will parents be informed about incidents of drug use, and who will be responsible for contacting them?
3. Will the police be notified of incidents involving illicit drug use; if so, what is the procedure for police interviews or arrests of staff or students?
4. What will be the role of outside organizations, such as those for drug or alcohol counselling, and who will coordinate referral to them?
5. What welfare and counselling services will be made available to staff or students who are in an incident involving substance use or come forward with a problem or concern?

This section raises the above issues only to provide guidance. The assessed needs of each school and the need for compliance with local and national regulations should determine the school's policy on substance use.

7

Youth Organizations

TRADITIONAL ORGANIZATIONS

Youth organizations are often important in the lives of young people, offering them recreational facilities and a chance to socialize with peers in a safe environment. Although their aims and purposes may differ, these organizations are increasingly expanding their services to encompass issues of concern to young people, including substance use and related problems. Such work is often similar in approach to that undertaken in schools: developing general and situation-specific skills, increasing knowledge and influencing attitudes and behaviour. Peer education methodologies are especially suitable for use in youth club settings.

Outside of the school and home, youth organizations provide perhaps the greatest opportunity to undertake face-to-face preventive work with young people. It is increasingly recognized that many of the activities of these organizations can be used not only to enhance the personal and social development of young people but also to deliver appropriate information and messages about alcohol, tobacco and drugs. Young people are perhaps more receptive to such messages in the relaxed, open setting of a youth or sports club. These settings are also a means of reaching school-leavers and young people who are not, for whatever reasons, regular school attenders.

Another advantage of the club setting is that young people may wish to seek information and advice about substance use from a credible person who is not an authority figure. In giving information and advice on substance use, youth workers are often in the front line. Drug and alcohol problems increasingly come to the attention of

youth workers, who may not have adequate resources to address them. Many of these workers have requested training in preventive work and intervention counselling. They need to feel well informed and confident about the substance-related work that they do. As a matter of course, youth workers should be trained and updated on issues in prevention and harm minimization. In the Flemish-speaking region of Belgium, the Vereniging voor Alcohol- en andere Drugproblemen VZW (VAD) is involved in systematic exercises to raise the awareness of people who work with the young. Community drug agencies and drug prevention groups can often play an important role in educating and training traditional leaders of youth groups, young people and parents about substance use issues. Other agencies and groups can contribute through, for example, theatrical and musical shows and workshops that include building skills, making and presenting videos and films, and answering the questions of parents and children. Many fun and creative activities can be given a preventive slant.

COMMUNITY SPORTS GROUPS

Many activities to prevent drug use take place in community sports groups. Work in this setting often takes the form of a general campaign to raise awareness and set norms, rather than specific, one-to-one work with young people. In Germany, for example, the German Football Association (DFB), the German Track and Field Association and the German Tennis Association all cooperate in the "No Power to Drugs" initiative, which is sponsored by Federal Chancellor Helmut Kohl and managed by the Federal Ministry of Health. In addition, the German Federal Centre for Health Education cooperates with DFB on the campaign "Who needs cigarettes?" for junior football teams.

In many countries, professional sports associations are involved in preventive work with schools, as well as with youth sports groups. In some areas of the United Kingdom, for example, professional rugby and football clubs work with the police and other agencies in delivering drug education in schools. This approach is popular with young people, adding credibility to the messages given by the school and other authority figures.

PREVENTION CLUBS

Aside from the traditional recreation and leisure clubs, organizations have been formed as a direct result of concerns about substance use by young people. For example, nonsmoking clubs have proliferated in recent years. In French-speaking Belgium, the Fondation contre les affections respiratoires et pour l'éducation à la santé (FARES asbl) recently founded "Première génération sans tabac" to promote a healthy lifestyle without tobacco among young people. With over 84 school clubs and 17 000 members, the organization publishes a newsletter with information, advice and games for its young members. The clubs take part in fun and informative preventive and health promoting activities. Similar clubs have developed elsewhere.

In the United Kingdom, the "Smokebusters" clubs encourage children to reject smoking by:

- giving them the information, confidence and support to resist the pressures to start smoking;
- building a strong peer group network to support nonsmoking children;
- presenting nonsmoking as the positive, adult, attractive and fun choice to make;
- encouraging members to play an active part in the club and in creating a smoke-free environment; and
- promoting a healthy lifestyle.

Like most similar clubs, Smokebusters clubs address children aged 9–14. Statistics show that this age group has the greatest risk of starting smoking. Administered through health promotion units, schools, youth groups, government-backed initiatives and local Action on Smoking and Health groups, local clubs recruit members through schools, from other local youth groups or on an individual basis. Members receive a start-up pack and newsletters, and are involved in all manner of group activities, as well as environmental campaigns and petitions (for example, to enforce smoking bans on buses). These clubs are immensely popular with the target group, as well as with schools, school boards and parents' organizations. Membership in a Smokebusters club is considered fashionable.

Various youth sobriety movements are involved in preventing alcohol and drug use. This approach appears to be popular in central and eastern European countries. In Lithuania, for example, many associations work through or within schools to organize seminars and weekend camps, and to publish special newspapers.

Young people in other groups take an active part in educating their peers about substance use. Members work with community agencies to research, design, test, disseminate and evaluate innovative resources, such as comic books, videos and plays. Many groups focus on a problem that they feel is not adequately addressed by existing services, such as drug use at dances. Funding for these groups comes from a variety of sources.

ORGANIZATIONS FOR YOUNG PEOPLE AT RISK

Social work and judicial departments often supply resources for clubs and activities for young people who are either involved in drug use or living in areas where its prevalence is high. The immediate objective of such organizations is to provide young people with stimulating, creative and often physical activities that are incompatible with substance use. Communities often have very little to offer young people, and some turn to drugs out of boredom, frustration and lack of opportunities. In the long term, it is hoped that young people who have a variety of options and who have acquired skills and self-confidence will not feel the need to use drugs. These clubs are usually staffed by specially trained youth or drug workers and sometimes have both static and mobile facilities. Some clubs are attached to or work with particular drug prevention services.

For example, the "Crazy Girls Project" in Lahti, Finland works in conjunction with the city agency "Mono-Service" to help girls who are experiencing social problems due to drug and alcohol use (such as those in danger of being removed from school or their homes). A rise in drug and alcohol use by girls under 16 had been noted. The Crazy Girls Project aims to prevent further drug use by involving the girls in activities that enhance their self-esteem and self-worth. Parental involvement is also a key feature. The girls are contacted through the Mono-Service and pledge to remain drug- and alcohol-free while

involved in the Project. The workers are volunteers trained by the service for social work with young people. Funding comes through the temporary, city-wide Lahti Project. Continued funding from a permanent source has not been guaranteed, although the work is seen as very important to the city's preventive efforts.

SUPPORTIVE POLICIES AND PROCEDURES

Youth organizations should have a policy and set procedures on substance use. Clear guidelines about when, how and where the use of alcohol and tobacco is acceptable are believed to have a substantial preventive effect (59). Organizations such as VAD help clubs to devise workable guidelines. Collaboration with local schools, departments of public health and health promotion, government health and welfare departments, the police and other agencies can ensure that consistent and appropriate messages and information are imparted, and provide expertise and ideas for preventive work.

CONCLUSIONS

Problems with alcohol, tobacco and drug use are increasingly coming to the attention of those who work with young people. Organizations for young people can be used to provide education on substance use in implicit or explicit ways. Youth workers need training to acquire the skills and knowledge to educate on and intervene in substance use. In addition, young people are involved in educating their peers on substance-related issues. This approach has consistently shown positive behavioural results. Work of this nature should be encouraged and funded, so that the people and agencies involved can share experiences, approaches and methodologies with others.

Addresses

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c/o Education Officer (Smokebusters)
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Smokebusters Wales
c/o Smokebusters Co-Ordinator
Health Promotion Authority for Wales
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Ty Glas Avenue
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Mono-Service/Crazy Girls Project
Mariankatu 11
15110 Lahti
Finland

8

Prevention-related Events and Projects

Many innovative projects, initiatives and events to prevent the harm from substance use have taken place in the European Region. Some are national or international events (such as European Drug Prevention Week) while others are of a more local, targeted nature. Most are cooperative efforts, in which interested organizations help with financing, coordination and expertise. Sometimes young people themselves develop and coordinate events and projects. Youth events are sometimes linked with broader community initiatives for health promotion, which increases the relevance and impact of the message to young people.

Many projects and events are intended to promote healthy lifestyles and to empower young people to make healthy decisions now and in the future. They do not always directly address substance use. Those that do address this topic most often emphasize a position and creative expression of the advantages of not using alcohol, tobacco and drugs. In general, young people do not find negative messages or scare tactics to be credible. The same principles apply to preventive work inside and outside the school: the messages, information and activities need to be relevant to youth, appropriate to the target group, nonjudgemental or nonstigmatizing, and compatible with societal norms. The following are some examples of youth events and projects.

A NATIONAL ACTIVITY

A music contest was held in Denmark for the 1994 European Drug Prevention Week. The National Board of Health coordinated the project with the National Youth Circle and a county consultant on alcohol and drugs.

The contest, called "The Slide", was a peer project for young people between 14 and 21 years of age. Amateur rock bands, drawing on their own and others' experience, expressed their views through text and music on why some young people slide into the use of drugs and alcohol. A jury of representatives from top Danish rock bands selected the 15 best numbers, which were recorded on compact disc. Schools and youth clubs can borrow the disc through the Centre for Teaching Materials. In addition to the honour of having their songs recorded, the 15 winning bands received star treatment during the recording sessions and press conferences and receptions in their youth clubs and schools. Further, local radio stations were invited to the recording sessions.

The basic idea of the campaign was to appeal to young people's dreams of stardom to make them consider the problem of substance use and express their thoughts in music. The competition not only acknowledged the work of the participants but also created material that benefited others.

LOCAL ACTIVITIES

Stop Multiple Drug Use

As an activity for the 1994 European Drug Prevention Week and in response to a growing tendency for young people to mix alcohol and different pharmaceuticals, a radio campaign called "Stop Multiple Drug Use" was carried out in the County of Ribe, Denmark, to address people aged 16–24 years. Local radio stations produced and broadcast interviews, facts, music and competitions dealing with the risks associated with alcohol and drug use. They also gave the telephone numbers and addresses of sources of help and advice. In addition, adults were the targets of newspaper advertisements, which encouraged them to clean out their medicine cabinets and to reduce

their use of pain-killers and tranquillizers. The week-long campaign thus addressed both young people and their parents, reinforcing and spreading the message. Simultaneously, information was provided on how to change current behaviour. The coordinator of the campaign was the drugs consultant in the Department of Health and Prevention in Ribe.

6VT – Edinburgh City Youth Café

The Edinburgh Youth Café is a substance-free coffee and snack bar, established to meet the needs of people aged 15–20. Located in the city centre, the Café offers social and recreational facilities, including live music, and provides informal educational workshops on a wide range of issues. The objectives are:

- to provide a safe environment for young people, through which social issues and concern can be addressed;
- to encourage young people using the Café to take a major responsibility for its organization and management;
- to provide a high-quality advice and information service to allow clients to make informed decisions about their lives and to support them in putting these decisions into action; and
- to offer appropriate experiences through which young people will have the chance to learn about themselves and to become more effective in their relationships with others.

In addition to providing information, the project also undertakes long-term one-to-one work with young people and acts as a referral agency to other, more specialized services. The information and advice service covers a wide range of issues, including housing and homelessness, consumer issues, credit and debt, substance use, welfare benefits, general and sexual health, and educational and leisure opportunities in the community.

The Café is open weekday evenings and weekends, and is staffed by full- and part-time workers employed through a grant from the local government council (Lothian Regional Council) and by voluntary workers. Young people are involved in planning, organizing and managing the project through the management committee. Other members of the committee include representatives of the

regional and district councils, other youth projects and agencies, and the local residents' association.

The Edinburgh City Youth Café is a registered charity, with funds coming from a wide variety of sources, including a local government grant and charitable trusts.

Unlike projects that primarily provide substance-free leisure facilities for young people, the Edinburgh City Youth Café focuses on advocacy, involvement and empowerment within an environment free from commercial pressures. This difference is thought to be important to the success of such facilities. Ventures of this type that do not address the concerns of young people do not usually survive.

Addresses

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Project Coordinator
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9

Conclusions

The collective evidence from the etiological, epidemiological and prevention literature and from experts in the European Region shows that, despite preventive efforts, young people continue to be at risk from the use of alcohol, tobacco and drugs. Although the use of alcohol, tobacco and drugs leads to relatively little personal harm for most young people, the collective harm incurred requires to be addressed by all sectors of the local and global communities.

Preventive education in schools is seen as the primary means by which students can acquire the knowledge and skills to make informed choices about substance use. Peer-led, life skills and social influence approaches to prevention have produced replicable, positive behavioural results. Because many internal and external factors influence young people's decisions about substance use, however, classroom efforts need reinforcement and support from the whole school, parents and the local community. They should create a climate in which healthy choices are normative choices. Healthy public policy in this area can include controls on the price and availability of alcohol and tobacco, restrictions on advertising and promotion, and the support of cessation efforts. These and other measures can reinforce the messages disseminated in schools and other locations.

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EUROPEAN ALCOHOL ACTION PLAN

Despite all preventive efforts, a minority of young people uses alcohol, drugs and tobacco. While this may not harm the users very much, the inappropriate use of substances causes harm to society that demands action from all sectors. The question is, what approaches are most successful in preventing substance use by young people?

This booklet – the eighth in a series of nine – tackles this question by:

- examining the literature on substance use and its effects
- describing various preventive approaches and programmes in schools and communities
- giving guidelines for preventive work.

Approaches that involve peer leaders and address the influences on substance use are the most effective in changing behaviour. All preventive measures, however, no matter where they are taken, need reinforcement and support from society.

This booklet offers valuable and useful reading to anyone interested in preventing substance use by young people. It is particularly valuable to health, education and other professionals active in this field. Helping young people to promote their health by avoiding substance use is an important contribution to health for all.

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